HEALTHSTART
COMPREHENSIVE MATERNITY CARE SERVICES
PROGRAM GUIDELINES

JANUARY 1997

Division of Family Health Services

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INTRODUCTION

In 1985, Governor Kean directed his Office of Policy and Planning to develop a series of initiatives capable of addressing New Jersey's most pressing health problems. Consistent with this directive, a new health care program for low-income women and children was conceptualized and presented in the Governor's 1986 State of the State message. Enabling state legislation for the new services program, HealthStart, was signed into law on May 4, 1987 and first implemented in February 1988. The goal of HealthStart is to reduce the incidence of low birthweight and infant mortality and to improve child health status by offering unique comprehensive packages of maternal and child health services for pregnant women and children throughout New Jersey who are eligible for Medicaid.

HealthStart is a Medicaid program. However, as specified in the legislation, the planning and implementation of HealthStart is a joint effort of the Department of Health and Senior Services and the Department of Human Services. The Department of Health and Senior Services is delegated responsibility for development and updating of program standards and guidelines, issuance of provider certificates, and evaluation and quality assurance.

Two expanded, enriched, Medicaid service programs are offered through HealthStart: comprehensive maternity care and preventive pediatric care.

Only the Comprehensive Maternity Care, a cohesive package of services, will be described, herein, the features are:

- presumptive eligibility by those providers who are eligible and approved;
- initial, subsequent, and postpartum comprehensive assessment;
- development and maintenance of a Plan of Care for each patient;
- medical care services including 15 prenatal and 1 postpartum ambulatory care visits recommended by the American College of Obstetricians and Gynecologists (ACOG) and the American College of Nurse Midwives (ACNM) standards, medical delivery and postpartum in-patient services, and admission arrangements for delivery;
- case coordination services including identifying a case coordinator for each patient and vigorous follow-up, support and advocacy;
- nutrition assessment, basic guidance, and counseling;
- social/psychological assessment, basic guidance, and counseling;
- health education assessment and instruction;
- home visits (as needed), for preventive health care and high risk;
- 24 hour access to emergency medical and case coordination services; and
- linkage with pediatric care, WIC for mother and baby, future family planning and other needed services.

HealthStart is the result of the cumulative efforts of many diverse groups and individuals who participated in the planning and development process. The HealthStart regulations and guidelines are the product of the work of staff from the HealthStart Project, Department of Human Services, Department of Health and Senior Services, and health care professionals throughout New Jersey and in other states. Special appreciation is due to the New Jersey health care professionals who participated on the Services and Providers Technical Advisory Panel and its sub-groups. Another special note of thanks is due to the out-of-state experts who provided valuable ideas, commentary, and service manuals. The guidelines are designed to assist providers with implementation of the regulations, and should be read and utilized in conjunction with the regulations.

During 1994 and 1995, a subcommittee of the Department of Health and Senior Services Parental and Child Health Advisory Committee was convened to review the "HealthStart Guidelines 1989." The subcommittee was comprised of a cross section of HealthStart provider's professional staff, and HealthStart Program staff from the Department of Health and Senior Services and Department of Human Services. Revisions recommended by the subcommittee have been incorporated into this document.

HEALTHSTART COMPREHENSIVE MATERNITY CARE SERVICES

HEALTHSTART COMPREHENSIVE MATERNITY CARE SERVICES

OVERVIEW

The primary objective of HealthStart comprehensive maternity care services is to provide women in New Jersey with a comprehensive package of care which addresses all areas of their lives likely to affect their pregnancy outcomes and the health of their infants. In order to assure that the HealthStart program meets this objective, regulations and guidelines have been developed which emphasize that services be structured and function as a single package.

The services are a "package" in the sense that ONE primary provider, (individual or organizational entity) is responsible for coordinating all of the services and ensuring that they are delivered in the appropriate fashion. When the maternity care package is offered by two or more providers, they will designate one of them as having primary responsibility.

The services are also a "package" in the sense that mechanisms for coordination among them and continuity over time are built into the program requirements and guidelines. These mechanisms include case coordination; comprehensive initial, periodic, and postpartum assessment; development and implementation of a written Plan of Care; and an initial orientation for all patients concerning the process and content of prenatal care and their rights and responsibilities. Case coordination refers to activities designed to provide the client with care that is continuous, well- integrated, and tailored to her individual needs, and includes active follow-up activities designed to insure that the plan of care is being followed and revised as needed.

The service package contains two major components: medical and health support services. The medical component includes obstetrical prenatal, intrapartum and postpartum care services. Health support services include: case coordination, health education, nutrition, and social/psychological services and home visits.

Certain principles have guided development of the program regulations and guidelines. Stating these principles will assist the provider to implement the spirit as well as the requirements of the maternity care package.

1. The primary provider carries the RESPONSIBILITY for insuring that services are available, accessible, and that the client understands the need for and is supported to receive early and continuous maternity care. In keeping with the principle, the provider is responsible for minimizing all potential barriers to services such as, but not limited to, waiting time, financial, language barriers, physical distance, and/or fragmentation, etc.

2. The services are to be delivered in a manner which encourages the client to take a more ACTIVE ROLE in her own health care. All efforts to inform the client about the content and process of maternity care, related health matters, and her rights and responsibilities serve this objective, as do any efforts to help her improve her planning, communication, and problem solving skills. Vigorous outreach and follow-up provides crucial social support necessary for behavior change towards a more active role as an informed health care consumer.

3. The services are to be COMPREHENSIVE so that any aspect of the woman's life that is likely to impact on birth outcomes and infant health status is assessed and appropriate services provided or obtained.

4. The services need to be well COORDINATED and CONTINUOUS.

5. Services are to be delivered in a manner recognizing and supporting the INDIVIDUAL CHARACTERISTICS of the client, such as age and cultural background. Implementation of this principle includes but is not limited to assessment of the client's characteristics, lowering of language barriers, and adapting health education, nutrition and social/psychological services, whenever possible, to fit the client's particular values, abilities, and family/social structures.

The guidelines for the maternity care service package include these sections: Obstetrical Care, Case Coordination Services, Health Education Services, Nutrition Services, Social/Psychological Services, Plan of Care, Home Visits, Outreach, and Evaluation.

The comprehensive assessment of the maternity patient includes all service areas and has features common to all areas. In each service area, an outline of topics/information to be collected is provided for each phase of the assessment.

All information to be collected in each service area is to be recorded in the patient's record using the same tool for all patients. The record should be legible and include information necessary to fully disclose the kind and extent of service provided, signed with the provider credentials and dated. It is the provider's responsibility to decide on an assessment tool(s).

The main purpose of the assessment is to identify the patient's level of risk for a poor birth outcome so that appropriate proactive management can be initiated.

Risk criteria are included in the obstetrical, social/psychological, nutritional, and health education assessments, most criteria being found in the obstetrical assessment.

The patient's overall level of risk must be assessed based on all risk factors identified and the Plan of Care written and implemented accordingly.

Below is a summary of the service package, including which basic services must be provided for all patients as opposed to which specialized services must be provided only to patients who need them.

Basic Services:-

Medical:	Initial prenatal, 14 subsequent prenatal and 1 post partum visit; (including level of risk assessment)
Case Coordination:	All services for all patients;
Health Education:	Assessment, including level of risk, (initial, subsequent and postpartum) and basic instructions;
Nutrition:	Assessment, including level of risk, (initial, subsequent and postpartum) and basic guidance;

Social/Psychological:	Assessment, including level of risk, (initial, subsequent and postpartum) and basic guidance.
Plan of Care:	Initiated during first visit and maintained (ongoing) for each patient;

Specialized Services:-

Medical:	Additional visits which are medically indicated.
Health Education:	Instruction guidance-decision making.
Nutrition:	Specialized assessment and counseling as needed.
Social/Psychological:	Specialized assessment and counseling as needed.
Home Visit:	If indicated, at least one prenatal and one postpartum, to patients identified as high risk, needing skilled nursing care or preventive health care.

ORGANIZATIONAL STRUCTURE

The organizational requirements permit many models for structuring HealthStart services (see Appendix for figures).

HEALTHSTART OBSTETRICAL SERVICES

HEALTHSTART OBSTETRICAL SERVICES

INTRODUCTION

The program guidelines for maternity obstetrical services include the following sections: Frequency of Prenatal Visits, Initial Prenatal Visit, routine laboratory tests, Subsequent Prenatal Visits, Special Screening tests, Delivery Services, and Postpartum Visits.

Obstetrical services shall be provided and coordinated by a physician and/or a certified nurse midwife and/or, when physician collaboration exists, a certified nurse practitioner/clinical nurse specialist (CNP/CNS). All services are to be recorded in the patient chart.

ACKNOWLEDGMENT

Initial and ongoing assessment of the patient status and attention to risk factors are the key components of the antepartum care.

These program guidelines are based on medical services recommended by the American College of Obstetricians and Gynecologists (ACOG) and the American College of Nurse Midwives (ACNM) standards, and are printed with the permission of the respective College.

Frequency of Prenatal Visits

The frequency of prenatal visits should be determined by a woman's individual needs and risk factors. Generally, for an uncomplicated pregnancy the frequency should be every four weeks during the first twenty-eight weeks; then every two to three weeks until thirty-six weeks of gestation; and weekly thereafter; or in accordance with standards recommended by the American College of Obstetrics and Gynecologists (ACOG) and/or the American College of Nurse Midwives (ACNM). Additional prenatal visits for medical and/or obstetrical complications should be scheduled as needed.

During the Initial Prenatal Visit an obstetrical data base should be established for the patient that includes a comprehensive health history, information on the current pregnancy, a family and social history, the findings of a physical examination, the results of laboratory procedures, and RISK ASSESSMENT. The content shall include:

HISTORY - FAMILY: major medical problems/diseases, genetic disorders, multiple births; PERSONAL: medical/surgical, diseases, hospitalizations, surgery, chronic illnesses, allergies, transfusions, hepatitis B; REPRODUCTIVE/GYNECOLOGICAL: disorders, menstrual history, listing of all pregnancies and their outcomes/complications, DES exposure, contraceptive and sexual history, confirmation of present pregnancy and gestational status; SUBSTANCE USE alcohol, tobacco, drugs, medications (OTC, prescription); BEHAVIORAL/ENVIRONMENTAL: occupation, employment history, exposure to chemicals, physical activity; NUTRITIONAL: review of nutrition assessment, prepregnant weight, change in diet, eating of non-food items, supplements, deficiencies; SOCIAL/PSYCHOLOGICAL: review of social/psychological assessment, history of mental disorder, environment, family, support person, presence of support from significant other, emotional state concerning pregnancy.

COMPREHENSIVE PHYSICAL EXAMINATION - weight, blood pressure and other vital signs; head and neck; chest - lungs, heart, breasts, nipples; abdomen - fundal height, fetal presentation, **fetal heart location and rate (after 1st trimester);** extremities - edema, peripheral circulation, skeletal abnormality; pelvic examination - cervix, pelvic configuration and capacity, uterine size and shape; rectum.

RISK ASSESSMENT - **Assessment of risk factors should be completed on initial visit and subsequent visits, throughout the pregnancy. Based on the findings of the history and physical examination a risk assessment tool (see appendix for sample tool) should be utilized for indicating any risk factors and to identify patients "at risk" of poor pregnancy outcomes that may requires special management. Medical "at risk" should be determined by the obstetrical care provider based upon recognized professional standards of care and sound clinical judgement.**

These factors must include but are not limited to:

Obstetrical History: Age under 18 or over 34; two (2) or more spontaneous or induced abortions; fetal/neonatal/post neonatal death(s); SIDS death(s); previous preterm labor or premature births; previous SGA or low birth weight infant; previous birth nine (9) pounds or more; previous gestation of 42 weeks or more; previous personal or family history of multiple births; previous obstetrical complications (antepartum hemorrhage, pregnancy induced hypertension, cesarean birth, PROM, thromboembolic, incompetent cervix); previous operations on the uterus or cervix (other than routine D&C); pelvic, uterine or cervical abnormality affecting positive pregnancy/delivery outcomes; previous infant with major congenital or chromosomal anomaly; previous isoimmunization; previous infertility.

Medical History: Pre-existing conditions such as: diabetes; renal or lung disease; heart disease; hypertension; metabolic disorder; seizure or other neurologic disorder; autoimmune condition; hemoglobinopathy; neoplastic disease; personal or sexual partners history of sexually transmitted disease(s), or multiple sexual partners; history of other non-GYN surgery; history of potential hereditary disorder.

Current Pregnancy Status: Interpregnancy interval less than (1) year; inadequate prenatal care; multiple pregnancy; maternal use of prescription drugs early in pregnancy; maternal use of drugs, alcohol, tobacco; maternal exposure to radiation, organic solvents, heavy metals; gestational diabetes; pregnancy induced hypertension/eclampsia; sexually transmitted disease(s); poor or excessive weight gain; hyperemesis; abnormal uterine bleeding; spontaneous premature rupture of membranes; oligo or poly hydramnios; decreased uterine size; anemia; potential for Rh or ABO incompatibility; rubella negative titer.

RISK MANAGEMENT - **Identification of high risk factors may require special management. The obstetrical care provider shall determine the appropriate management of care including specialized consultation and/or transferring the patient's care to another facility and/or provider. This shall be documented in the patient's record. The obstetrical care provider shall inform the pediatrician of identified risk factors that may have significant impact on the fetus.**

ROUTINE LABORATORY TESTS -

NOTE: Human Immunodeficiency Virus (HIV) information, counsel and testing shall be offered to ALL pregnant women on a routine basis (Public Laws of 1995, Chapter 174, July 7,1995). A Department of Health and Senior Services "inform consent" form (see appendix) must be completed for each patient and retained as a permanent part of patient's medical record. Also: **FYI -** Many recent studies have found bacterial vaginosis (a condition resulting from a major shift from the normal lactobacilli of the vagina, to a high concentration of mixed bacteria) to be a risk factor for increased infant mortality. Bacterial vaginosis has long been considered as a nuisance problem and has been associated with preterm delivery of low birth weight infants independently of other risk factors.

Complete urinalysis, cultures, sensitivity as indicated;
Complete blood count;
Rh factor, blood typing (Rh negative patients require additional screening);
Antibody screening for irregular antibodies;
Serological test for syphilis;
Culture for gonorrhea;
Papanicolaou smear;
Hepatitis (HB_s A_g);
Rubella antibody screen, as indicated;
Tuberculin test for high risk populations (i.e., close contact with a diagnosed case or from Department of Health designated high risk areas).

PROCEDURES - (at initial or subsequent visits as indicated)

Ultrasonography;
Amniocentesis;
Appropriate genetic counseling and testing;
Non-stress test/Contraction stress test;
X-ray pelvimetry;
Other procedures as medically indicated.

SCREENING TESTS - As medically indicated:

Hepatitis B surface antigen (at 28 weeks);
Toxoplasmosis titer;
Herpes culture;
Chlamydia culture;
Group B Beta hemolytic - Strep culture;
Cytomegalovirus test;
HIV antibody screening (as recommended by the Department of Health and Senior Services), with pre-counseling and post-counseling and a Department of Health and Senior Services "informed consent" form, (see appendix);
Maternal serum alpha fetoprotein (at 16-18 weeks);
Culture for gonorrhea (at 36 weeks);
Sickle cell (Hemoglobin electrophoresis or equivalent).

Subsequent Prenatal Visits

NOTE: Chorionic villi testing and/or amniocentesis shall be offered to all women thirty-five (35) years of age or over. These tests shall be provided or arranged for as indicated by risk and maternal consent.

REVIEW OF PLAN - Support/provide maternal education on feeding of newborns with counseling and support for breast feeding; instruction on breast self examination; discussion of postpartum future family planning; status of referrals; instruction on admission for delivery; **arrangement for delivery at appropriate facility (32-36 weeks, no later than 36 weeks);** introduction to labor and delivery unit; **transfer of medical record (32-36 weeks).**

INTERIM HISTORY - Signs/symptoms - bleeding, edema, headaches, dizziness, poor diet, activity/exertion/rest, signs of preterm labor; progress/changes - fetal movement; concerns/questions.

PHYSICAL EXAMINATION - Vital signs; weight gain/loss; varicosities/edema; **fetal presentation - tape measurement of fundal height, fetal heart rate;** pelvic examination (at 36 weeks or as indicated).

LABORATORY TESTS - Urinalysis for glucose, acetone and/or nitrates, albumin (at each visit);
Blood glucose (at 24-28 weeks); Hemoglobin/Hematocrit (at 28 weeks); Serological test for syphilis (at 28-36 weeks); Rh titer (at 28-32 weeks, if indicated) [Note: Rhogam at 28 weeks, if indicated];
Additional testing as medically indicated.

Delivery Services

Obstetrical delivery and patient treatment during postpartum stay provided directly or by previous arrangement.

Postpartum Visit

The postpartum visit shall be provided within four-six (4-6) weeks after delivery (or sooner if indicated).

HISTORY - Review of prenatal, labor, and delivery record; bleeding, discharge, bowel movements, urination, incision, breast/infant feeding, activity/rest, diet, headaches, dizziness.

PHYSICAL EXAMINATION - Weight, blood pressure and other vital signs; breast nipples: inspection and/or palpation as indicated; abdominal: including incision; pelvic: vaginal muscle tone, signs/symptoms of infection, uterine size and tenderness, cervix, lochia, perineum/episiotomy; lower extremities: edema, varicosities; further examination as medically indicated.

LABORATORY TESTS - Hemoglobin/Hematocrit; Papanicolaou smear (if more than 9 months since the last test); Other tests as medically indicated, based on prenatal, labor, delivery and post partum course.

PARENT/INFANT ASSESSMENT - Review social/psychological, health education, home visit(s) reports; status of infant feeding with encouragement/support for breast feeding; linkage with pediatric care; patient counseling and treatment - future family planning (prescription for contraceptive device as indicated), sexual activity, return to work, limitation(s) on activity.

REFERRAL/CONSULTATION - As indicated.

HEALTHSTART HEALTH SUPPORT SERVICES

HEALTHSTART HEALTH SUPPORT SERVICES

INTRODUCTION

Health Support services include:

- **!** Case Coordination Services - a mechanism for providing the patient with continuous, coordinated, and well integrated comprehensive services to meet the individual's needs throughout the prenatal and postpartum period.

- **!** Health Education Services - a mechanism for providing education instructions according to the content of a standard “Curriculum Guide” basic to pregnancy, birth and infant care and for providing basic guidance for making and implementing decisions which are likely to affect birth outcomes and infant health, growth and development.

- **!** Childbirth Education - a mechanism for providing a course which include content in accordance with the standards of a national organization devoted to childbirth education.

- **!** Nutrition Services - a mechanism for providing nutrition services at two levels. These levels, BASIC (assessment, guidance, referral) and when needed, SPECIALIZED (assessment, counseling and referral) are provided for review and reinforcement of nutrition and dietary needs and to identify nutritional risk factors.

- **!** Social/Psychological Services - a mechanism for providing social/psychological services at two levels. These levels, BASIC (assessment, guidance and referral) and when needed, SPECIALIZED (assessment, counseling and referral) are provided to identify those patients in need of additional services that are most likely to be related to poor outcomes.

- **!** Home Visit Services - a mechanism for assessing, supporting, and advocating for receipt of preventive health care, high risk care and skilled nursing care services (based on clinical judgement of appropriate clinicians or staff) which can best be delivered in the home setting.

- **!** Outreach Services - a mechanism for providing services aimed at individuals as well as those aimed at reducing system wide barriers that effect the enrollment process to facilitate early entry into maternity services and to encourage continuity of care.

- **!** Comprehensive Assessment - a mechanism for including all service areas with features common to all areas. In each service area an outline of topics/information to be collected is provided. **The PURPOSE of the assessment is to identify the patient's level of risk for a poor birth outcome so that appropriate proactive management can be initiated**. Risk criteria are included in the obstetrical, social/psychological, nutritional, and health education assessments, with most criteria being found in the obstetrical assessment. The patient's overall level of risk MUST be assessed based on ALL risk factors identified and the Plan of Care written and implemented accordingly.

- **!** Plan of Care - a document with integrated sections (medical, nutrition, social/psychological, and health education) to record identified level of risk(s) for a poor birth outcome so that appropriate proactive management can be initiated by the appropriate provider.

- **!** Evaluation, Monitoring, and Quality Assurance - a mechanism for three interrelated activities (that will be initiated at the beginning of the program and continued on an ongoing basis) to assess the degree and success of program implementation, operation, conformance with established standards, and impact throughout the State.

- **!** Documentation - a mechanism for writing, signing, credentialing and dating care provided to the patient. Shall be legible, adequate and sufficient as are necessary to fully disclose the kind and extent of services provided (see reimbursement rates in appendix).

All information collected is to be recorded (documented) in the patient's record using the SAME tool for all patients. It is the provider's responsibility to decide on a record and assessment tool(s).

This section of the program guidelines, for Health Support Services, include the following: **Criteria**; **Staffing**; Follow-up; Referrals; Plan of Care; Health Support Prenatal **Activities with Assessments: Initial, Subsequent, Specialized**, **Basic Guidance and Counseling**; Home Visits; **Outreach**; Health Support Postpartum Activities; **Evaluation, Monitoring, and Quality Assurance.**

CRITERIA

Case Coordination Services - A case coordinator is to be assigned to each patient at the first/registration/enrollment visit and case coordination services shall be provided throughout care. PARAPROFESSIONAL HEALTH WORKERS (licensed practical nurse, LPN, etc.) can effectively assist with case coordination services under the supervision of the case coordinator.

Plan of Care - A document (see appendix) with integrated sections (medical, nutrition, social/psychological, and health education) shall be developed no later than one (1) month after the first enrollment visit and reviewed/updated throughout care.

Health Education Services - Health education assessment and instruction shall be provided to ALL patients (according to contents of a standard "Curriculum Guide" see appendix). Basic guidance for making and implementing decisions basic to pregnancy, birth, and infant care shall be provided on an individual basis.

Childbirth Education - A childbirth education course shall be provided or arranged for ALL patients. Patients who have received this education during a previous pregnancy may be offered a "refresher" course.

Nutrition Services - BASIC nutrition services (assessment, guidance and referral) shall be provided for ALL patients. SPECIALIZED nutrition services (assessment, counseling and referral) shall be provided to those identified as in need of additional services.

Social/Psychological Services - BASIC social/psychological services (assessment guidance and referral) shall be provided for ALL patients. SPECIALIZED social/psychological services (assessment, counseling and referral) shall be provided to those patients identified as in need of additional services.

Home Visit Services - All patients must be assessed to determine the need for a home visit. If it is determined that the visit would be effective and meet agency's criteria for "preventive health care" and "high risk" a prenatal and/or a postpartum home visit (at least one) should be provided. All visits are subject to the clinical judgement of the case coordinator in conjunction with the medical care provider and other appropriate clinicians.

Outreach Services - Outreach activities shall be focused at ensuring early entry into maternity care and include efforts aimed at individuals as well as those aimed at reducing system wide barriers that effect the enrollment and retention process.

Evaluation, Monitoring, and Quality Assurance - These three interrelated activities shall be initiated at the beginning of the program by the provider and Department of Health and Senior Services staff and continue on an ongoing basis to assess program implementation, operation, conformance with established standards, and impact throughout the State. Appropriate tool(s) standard protocol should be utilized.

Maternity Services Summary Data Form (MSSD) - is to be submitted on each client who has received any HealthStart services including those services provided under code HFCA W9029 (see appendix). The form should be complete to the point of termination of HealthStart services to the client. Staff must be trained by the New Jersey Department of Health and Senior Services HealthStart staff. Maternity Services Summary Data forms are due in DHSS Program no later than ninety (90) days after termination of HealthStart services.

STAFFING *(Required minimum qualifications)*

Case coordination - Individuals providing any phase of case coordination activities shall have the following required minimum qualifications: a New Jersey license as a medical care professional (physician, certified nurse midwife, advance practice nurse (certified nurse practitioners/clinical nurse specialists, CNP/CNS), a registered nurse, a social worker with a New Jersey social work certificate/license, or a Bachelor's degree in a health, or behavioral science, or in Nutrition/Dietetics which meets the American Dietetics Association's R.D. educational requirements.

Health Education Services - Individuals providing the health education services shall meet the same minimum requirements as indicated above for case coordination and/or shall be a certified childbirth educator instructor.

Nutrition Services - Individuals providing the BASIC nutrition assessments (initial, subsequent, postpartum and including risk assessment, guidance and referral) shall meet the required minimum qualifications as indicated above for case coordination. **Individuals shall be referred for SPECIALIZED nutrition assessment and counseling services to an individual with a Bachelor's degree in Nutrition/dietetics which meets the American Dietetics Association's R.D. educational requirements.**

Social/Psychological Services - Individuals providing the BASIC social/psychological assessments (initial, subsequent, postpartum, guidance, and referral) shall meet the required minimum qualifications as indicated above for case coordination. **Individuals shall be referred for SPECIALIZED social/ psychological assessment and counseling services to an individual with a Bachelor's degree and a New Jersey social work license/certificate.**

Home Visit Services - Shall be provided by the appropriate clinicians or staff with the required minimum qualifications as indicated above for case coordination, or by written agreement. Home visit assessment can be done by a referral to a Local Health Department or Certified Home Health Agency under written agreement with the provider to complete home visits.

Outreach Services - Outreach can be provided by the HealthStart agency, or through linkage with community-based organizations like coalitions, churches, local public and private organizations or various educational media.

Evaluation, Monitoring, and Quality Assurance - This component is conducted by the HealthStart agency's staff and Department of Health and Senior Services staff. However, staff who prepare the Maternity Services Summary Data (MSSD) Form (see appendix) must be trained by the Department of Health and Senior Services, HealthStart staff.

FOLLOW-UP *(Prenatal, Postpartum)*

Follow-up on missed appointments (prenatal and postpartum) is an important part of provider-based case coordination activities. Providers are expected to make every effort to follow-up with patients who miss appointments as long as there is a reasonable chance of retaining the patient in maternity care.

At a minimum, the follow-up for any missed appointment(s) shall include but not be limited to the following steps, AS NEEDED:

- send appointment reminders and/or;
- make attempts to reach the patient by phone;
- send letters (receipt requested if applicable); and/or
- make at least one home or community-based, follow-up visit.

REFERRALS *(Prenatal, Postpartum)*

When a referral is initiated, the case coordinator shall assist the patient to assure that the patient understands the nature and purpose of the referral.
To assure timely completion of referrals, the case coordinator or staff member under her/his supervision should:

- know if the referral has been completed;
- assist the patient to identify barriers to completing the referral; and
- provide support to the patient and advocacy with the referral service unit(s) for reducing or eliminating the barriers to completion.

To implement follow-up on referrals, activities shall include but not be limited to the following steps, AS NEEDED:

- follow-up with the patient during prenatal visits:
- phone calls to the patient and/or referral service unit;
- letters to patient or referral service unit or where appropriate community-based agency;

PLAN OF CARE

Development of an integrated (medical, nutrition, social/psychological, and health education) plan of care, into ONE DOCUMENT, (see appendix) shall be completed no later than one (1) month after the first/registration/enrollment visit. The plan of care shall include: identification of risk conditions/problems, need(s), planned intervention(s), time frame(s), outcome objective(s), identification of care provider(s) responsible for the service(s), and plans for referral and follow-up activities.

Review and updating of the plan of care should be ongoing throughout the prenatal period with the patient and in **consultation** with professional staff involved in the patient's care.

The review includes but is not limited to examination of continuation of maternity care services (e.g. timely occurrence of patient visits); patient's health status (including medical, nutritional, and social/psychological status, and health education needs); patient's receipt of ALL basic services, needed specialized service, and initiation and timely completion of referrals; and identification of and arrangements for appropriate home visits if indicated (see home visit section).

HEALTH SUPPORT PRENATAL ACTIVITIES AND ASSESSMENTS

Case Coordination - (see appendix) Shall be provided to ALL HealthStart patients, includes but is not limited to:

During the first/registration/enrollment visit, to orient the patient to content and process of the comprehensive maternity care services including, what services will be provided as part of comprehensive maternity care (prenatal, intrapartum, and postpartum), including medical, laboratory, nutrition, psychosocial, health education, case coordination, home visit and outreach; who will provide these services; e.g., physician, nurse, midwife, advance practice nurse, registered nurse, social worker, nutritionist, health educator; where to go for services; e.g.,private office, private or hospital lab, independent clinic, hospital, local health department, WIC program, county welfare agency, family planning; when to go for services; e.g., timing of routine visits, childbirth education classes, prenatal health education classes, Medicaid determination, family planning, WIC; and if problems arise WHOM to contact and HOW to contact this person or avail herself of a service.

Additionally case coordination activities include:

Informing the patient about her rights and responsibilities (see appendix) regarding maternity care, both verbally and in writing. Monitoring and facilitate the patient's entry into and continuation with Maternity Care Services. Assisting patient in obtaining presumptive eligibility determination and monitor application for final Medicaid eligibility, when applicable. Assisting the patient to identify and provide advocacy which will assist in the reduction of barriers to continued care including waiting time, and fragmentation of services. Vigorous follow-up for missed appointments in order to assure that patients continue prenatal care as long as there is a reasonable chance of retaining the patient in maternity care. Contact information shall be compiled during the patient's first/registration/enrollment visit and updated at each subsequent visit. Reinforcement and supporting health teachings as needed, and coordinate professional and/or paraprofessional staff to provide these services.

Coordinating: - development of the Plan of Care and ongoing reviews/updates; services with other agencies e.g. WIC, Local Health Department, Certified Home Health Agency, coalitions, etc.; the assessment to identify the need for home visit(s) and prepare a written referral for the home visit(s) which includes the general and specific purposes and objectives of the visit(s), client characteristics, timeframes, and other pertinent information; obtain a written summary report **(within two week of the referral)** on each home visit completed which includes date, provider agency title and name of visitor, activities conducted, outcomes(s), and any pertinent information gained about the client, infant and home environment. For ongoing home visiting, the case coordinator should confer with the home visitor(s) ongoing to review the case.

Arranging case conference(s) and/or consultation with the obstetrical care provider and other professional staff as appropriate. Coordinating preparation of and completion of the Maternity Services Summary Data Form (MSSD) (see appendix). Reviewing, monitoring, and updating the individual records at each visit in order to assure that all services provided are legibly documented in the patient record, as necessary to fully disclose the kind and extent of services provided, signed, credentialed and dated and that pertinent copies, e.g. (referrals, P.E. FD 334 form, consultations, laboratory reports, etc.) are contained on the record.

Health Education - (see appendix) Shall be provided but not limited to:

Completing, for ALL HealthStart patients, an INITIAL health education assessment by reviewing existing information from other areas of assessment, and/or compiling general educational information (e.g. spoken language(s), education level, topics/information of immediate interest, previous and/or other health education, information, or experience concerning pregnancy, birth, infant care, and parenting).

Providing health education INSTRUCTION according to a standard "Curriculum Guide" (see appendix). All topics should be covered with modifications depending on the timing of the patient's entry into prenatal care.

Providing or arranging for a full "Childbirth Education" course (**at no cost to patient**) for all patients. This course shall include content in accordance with the standards of a national organization devoted to childbirth education. A "refresher" course can be provided for patients who have received childbirth education during a previous pregnancy.

Provide individual guidance for making and implementing decisions basic to pregnancy, birth, and infant care including but not limited to: changes in activity level (work, exercise, sex), changes in lifestyles (smoking, alcohol, substance abuse, environmental/occupational hazards), preparations for admission, infant care, pediatric care, and future family planning.

Plan for patient to see a/the specialist(s) if indicated.

Nutrition - (see appendix)

BASIC nutrition assessment (initial, subsequent and postpartum) using the "WIC/HS" form (see appendix), and guidance shall be provided to ALL HealthStart patients and shall include but not limited to INITIAL Nutrition Basic Assessment (including "risk" assessment) review of data from other parts of the assessments (particularly the results of laboratory tests), nutritional history, prenatal weight (including maintaining the "weight gain chart" HS-17 4/95), dental, eating disorders, metabolic conditions, special diets, medications, etc., nutritional inadequacies (24 hour dietary recall and/or assessment of food frequency for at least one week of time), appetite, fluid intake, pica, cravings, snacking, cultural, religious, myths, allergy, substance usage, alcohol, smoking, etc., GI discomforts, food preparation and refrigeration, household routines and activity level, assess for participation in "Food Supplement Programs".

All assessment information must be used (but is not limited to) in order to identify nutritional "risk factors", develop the "plan of care", and to identify the need for the nutrition specialists.

Plan (if indicated) for patient to see the nutritionist specialist.

A "New Jersey State Department of Health and Senior Services WIC/HealthStart Referral/Nutrition Assessment For Women Form" (see appendix), should be completed for the basic nutrition assessment and used for the initial referral to a WIC agency on all patients. If the patient is currently participating in the WIC program, maintain the completed form (all three copies) in the record.

SUBSEQUENT Nutrition Basic Assessment - includes but is not limited to: review of nutrition of mother, ongoing review for referral to food supplementation programs, monitoring weight gain (using a standard weight gain grid, see appendix) concerning adequate, inadequate, or excessive weight gain, review plans for infant nutrition and information patient has of myths, advice, etc. and specifics for implementing infant feeding (breast/bottle).

Plan for patient to see the nutritionist specialist if needed.

NUTRITION Guidance Basic - shall be, composed of but not limited to, providing information the general relationship of nutrition to positive pregnancy outcomes, instruction on food purchase, storage, and preparation, infant feeding and nutrition needs focused on assisting the patient to assess, choose and prepare to implement a feeding method, review and reinforcement of other nutrition and dietary counseling services, significance of referral to and participation in food supplementation programs.

Plan for patient to see the nutritionist specialist if needed.

SPECIALIZED Nutrition Assessment and Counseling - "Short term" specialized nutrition services shall be delivered by an appropriately credentialed nutritionist. The nutrition assessment and counseling shall be initiated (based on basic assessment and the patient's individual needs and in consultation with the medical care provider) at least for those patients having: inadequate or excessive weight gain, diabetes, pre-eclampsia , pica, anemia of pregnancy, chronic diseases or disabilities which complicate present pregnancy, impair dietary intake, dental conditions, inadequate food supply, etc.

EXTENSIVE - If the specialized nutrition services needed are extensive (e.g. highly complicated and/or intensive) they may be delivered by referral to the nutrition specialist on the provider's staff, or by referral, or by a combination of referral and the nutrition specialist. Referral for extensive specialized nutrition services must be initiated by the medical care provider or the nutritionist under the supervision of the medical care provider in coordination with the case coordinator based on clinical judgment and the following considerations:

- complexity and intensity of services needed;
- resources available at the HealthStart provider;
- availability of off-site specialized nutrition services, and
- accessibility of off-site specialized nutrition services.

Social/Psychological - (see appendix)

BASIC social/psychological assessments (initial-including risk assessment, subsequent, and postpartum) and BASIC social-psychological guidance shall be provided to ALL HealthStart patients and shall include but not be limited to:

INITIAL Social/psychological Basic Assessment (including "risk" assessment) - Review of existing information from other areas of assessment, client's perception of her IMMEDIATE needs or other needs, financial information and resources **(do not repeat this information if it has already been obtained, e.g. through presumptive eligibility (P.E.) (see appendix) determination, etc.)**, services currently received or applied for e.g. Medicaid, WIC, DYFS, other health or social services etc.; living conditions (her perception) dwelling, neighborhood, clothing, food, furniture, supplies etc.; family, personal and social support system (her perception) e.g. needs, children, father of baby,

friends, parents, relatives religious program(s), other organization(s) etc.; attitudes and concerns (perceptions/reactions to) view of this pregnancy, feelings positive/negative, overall status, hospitalization, mental status; major stress events within past year, e.g. death, illnesses substance abuse (self/someone close), abuse/neglect (physical/sexual); criminal justice system involvement; separation or divorce; other traumatic event of self or someone close; education and employment, goals/needs/plans; work experience, status, occupation, environmental hazards/problems; child/care arrangements (current and planned).

All assessment information must be used (but not be limited to) in order to identify social/psychological "risk factors", develop the "plan of care", and identify the need for the social worker specialist.

Plan for patient to see the social worker specialist if needed.

SUBSEQUENT social/psychological (see appendix) Basic Assessment - This assessment should utilize the same outline as the initial assessment. The focus should be on any major areas that could not be assessed initially, obtaining additional information needed, and updating the assessment of any major area. As with the initial assessment, subsequent assessment should result in identification of risk factors and a decision whether to provide further basic guidance or specialized assessment and counseling.

Plan for patient to see the social worker specialist, if needed.

Basic social/psychological GUIDANCE - includes: initial orientation and information on available community resources based upon the individuals needs, and should include specific information (names, telephone numbers) on emergency and non-emergency services in the area of financial assistance, mental health, housing, family violence and abuse, transportation, child care, education, substance abuse rehabilitation, infant clothing/equipment/care, and parenting education support etc. Referral, follow-up, support, and advocacy for basic social services. Orientation on stress and stress reduction and relationship of stress to pregnancy outcomes.

Plan for patient to see the social worker specialist, if needed.

SPECIALIZED social/psychological (see appendix) Assessment and Counseling - "Short term" specialized social/psychological services shall be delivered by an appropriately credentialed social/psychological specialist. The social/psychological assessment and counseling shall be initiated (based on assessment and the patient's individual needs and in conjunction with the medical care provider) at least for those patients having the following, but not limited to, situations: highly ambivalent, denying and/or rejecting of this pregnancy; history or suspected, mental health problems, developmental delay, handicaps or substance abuse, sexual/physical abuse or violence to/in patient or household; involvement with criminal justice system; serious social conflicts; weak or no social support system; other recent major (patient's perception) stressful, or life events; homelessness or pending or age 16 or less at time of delivery.

EXTENSIVE - If the specialized social/psychological services needed are extensive (see appendix) (e.g. highly complicated and/or intensive) they may be delivered by referral to the an appropriately credentialed social/psychological specialist on the provider's staff, or by referral, or by a combination of referral and the social/psychological specialist. Referral for extensive specialized social/psychological services must be initiated by the medical care provider or the social/psychological specialist under the supervision of the medical care provider and in

coordination with the case coordinator and shall be based on clinical judgement and the following consideration:

- complexity and intensity of services needed,
- resources available at the HealthStart provider,
- availability of off-site specialized social/psychological services, and
- accessibility of off-site specialized social/psychological services.

Home Visits *(Preventive Health Care, High Risk Needs, and/or Skilled Nursing Care)*

Home visits are an important and integral part of maternity care, particularly when serving a low-income population. Home visits should only be used to provide services which can best be delivered in the home setting and are particularly useful for patients who have special needs/risks which require assessment and intervention in the home, who have difficulty remaining involved in maternity care services, and/or who have difficulty implementing and adhering to health instructions and advice. Home visits are most effective when conducted by a visitor who is already familiar to the patient and who provides continuity across visits and should be coordinated with other services being delivered by the provider or by other community service settings.

Visits can be by an appropriately credentialed professional or paraprofessional team members, depending on the following consideration:

- the specific purpose of the visit;
- the skill and characteristics of professional and paraprofessional staff available; and
- the characteristics of the client and her level of rapport with various staff.

The provider shall provide or arrange, for at least one prenatal home visit for patients **IDENTIFIED** as needing preventive health care; with specific need(s)/risk(s); and/or skilled nursing care during the initial or subsequent prenatal assessment.

Additional home visit(s) shall be provided or arranged for the patients with specific need(s)/risk(s) if it is determined that visit(s) would be effective based on the clinical judgement of the case coordinator in conjunction with the medical care provider and other appropriate clinicians.

If a patient is receiving these services in her home from another agency(ies), the case coordinator may substitute those services for the required home visit. The case coordinator shall then coordinate services with the other agency(ies) and document the information in the patient's record.

"High Risk Care" Home Visit(s)

Patients shall be identified as high risk for the purpose of determining a prenatal home visit based on (but not limited to) the following criteria and subject to the clinical judgement of the case coordinator in conjunction with the medical care provider and other appropriate clinicians: Inability and/or lack of motivation to follow the prescribed plan of care; significant handicapping condition which effects ability to comply with the plan of care; new, persistent, and/or chronic, uncontrolled medical problem(s) which affect the pregnancy; identified current nutritional problems not responding to treatment; social high risk such as: alcohol or substance abuse, patient involvement with abuse/neglect, weak or no social supports, unstable or chaotic home environment; serious parenting inadequacies exhibited or suspected; current mental health problems; maternal age of 16 or less at the time of delivery with additional risk factor(s).

"Preventive Health Care" Home Visits

Home visits for preventive health care may be provided directly by a professional HealthStart provider staff or may be implemented by written agreement between the HealthStart provider and a local health department or independent, perinatal outreach team. A team approach consisting of health professionals and paraprofessional outreach workers is an effective way to provide continued preventive care home visits. However, it is important that staff continuity be maintained for home visits to any one patient.

Patients may benefit from a prenatal "Preventive Health Care" home visit indicators may include: Inability and/or lack of motivation to follow the prescribed plan of care; patients who exhibit or are suspected of serious parenting inadequacies; patients who demonstrate significant difficulty understanding and following instructions and/or linking with needed services; consecutive missed appointments and/or chronic missed appointment; the need to further assess to gain valuable information about the client's home environment, family/household system, the client, and the newborn infant; provide support and reinforcement of health teachings and advice to help the client assimilate and understand previous instructions and advice, and to assist the patient to practice and implement new health practices in her home environment; provide support and advocacy for social/psychological and other service needs and to establish linkages with services, arrangements for transportation and/or child care; accompany the patient as her advocate/supporter, act as an interpreter, provide informal counseling, and information and referrals on community resources to meet those needs; the need to increase trust, rapport and communication with the patient to increase the willingness and ability to utilize maternity care services and adhere to the plan of care.

"Skilled Nursing" Care Home Visits

These visits are for patients with diagnosed, documented medical needs that are best met in the home setting, need skilled nursing services and health teaching.

Home visits for skilled nursing care are arranged through referral to certified home health agencies. These visits must receive prior authorization from the Medicaid District Office and are reimbursable under the current Medicaid system, separate from HealthStart. Skilled nursing care visits must meet the criteria set by the New Jersey Medicaid program. **The case coordinator should arrange and coordinate these visits and facilitate obtaining the required written medical orders.**

COMMUNITY OUTREACH

The general purpose of "Community" outreach is to facilitate early entry into maternity services and to encourage continuity of care. Community outreach services include efforts aimed at individuals as well as those aimed at reducing system wide barriers that effect the enrollment process. Also, community-based individuals could provide information on the importance of prenatal care and encourage early client enrollment.

HealthStart providers who are in private practice settings are likely to benefit from becoming involved in outreach through linkage with community-based organizations that have established outreach services, or formalized assessment and planning for agency-based outreach. Outreach efforts include the following activities: Assessing socio-demographic characteristics of client population, educational levels, age, cultural and ethnic backgrounds and primary language spoken and/or read. Developing an outreach plan that will be culturally sensitive in order to effectively communicate with community groups. Identifying community resources and develop appropriate

linkages with coalitions. Being aware (knowledgeable) of various local public, private, and social organizations and health agencies, e.g. churches, teen groups, women's organizations and business groups, etc. Distribute and display HealthStart informational materials and identifying information (HealthStart certificate, posters, etc.) in such a way the clients are aware that the provider is certified as a HealthStart provider. Distribute give-aways, that are donated by local business community.

Form a local speakers bureau of key individuals from private and public organizations to publicize maternity care services. These presentations could include "testimonials" from maternity clients on the value of prenatal care. Develop partnerships with community-based organizations, coalitions, and churches in planning various maternity care outreach activities such as volunteer community action campaigns, educational sessions, "Health Fairs", "Bring a Friend to Prenatal Care", "Baby Showers", etc. and develop ways to work cooperatively in the areas of outreach.

HEALTH SUPPORT POSTPARTUM ACTIVITIES

Case Coordination

The case coordinator shall arrange and coordinate one contact preventive health care activity for ALL patients during the time after hospital discharge and prior to the required four - six (4-6) weeks Medical visit after delivery.

This postpartum activity shall be documented (see appendix for sample tool) in patient's record, include but not be limited to:

> Review of mother's health status; review of infant's health status; review of mother/infant interaction; assess the need for any additional services; assess the need for a home visit(s) and as appropriate provide or arrange for a home visit for mothers or infants **IDENTIFIED** as high risk; arrange for one regular Medical provider/clinic visit at four - six (4-6) weeks after delivery; arrange to obtain the "Labor, Delivery, and Postpartum Hospital Summary" record no later than two (2) weeks after hospital discharge, review and then incorporated into the patient's record; arrange linkage/referral of the patient to the appropriate service agencies, e.g. WIC, pediatric care, family planning, and other social and health services, such as Special Child Health Services Case Management Units, etc; arrange for the transfer of pertinent information or records to continuing service providers notable pediatric care and family planning service providers; vigorous follow-up on missed appointments (same guidelines as for the prenatal period); reinforce and support health teachings for mother and baby (same guidelines as for the prenatal period; review, completion and CLOSE of the plan of care; submit if applicable, the Maternity Services Summary Data Form (MSSD), (see Evaluation Monitoring and Quality Assurance section and appendix) within the required time frame to the Department of Health and Senior Services, Maternal Child Health, Epidemiology program HealthStart program.

Health Education

This postpartum activity shall include but not limited to:

> Review of previous assessments and patient record; review of health education curriculum; identify and answer patient's questions concerning infant care and development and postpartum maternal care; identification of patient's remaining needs; address remaining needs by referral or direct provision of services; follow-up on decisions from third trimester as needed; preparations for basic infant care, pediatric care for infant, future family planning services, and other continuing Medical and Dental care; review, completion and CLOSE of the plan of care.

Nutrition

This postpartum activity shall include but not limited to:

Review of MOTHER'S current nutritional status and needs, ideal perceived body weight, nutrient inadequacies (24 hour recall and/or assessment of food frequency for at least one week of time), fluid intake, pica cravings/consumption, snacking patterns, appetite as described by patient/appetite changes, allergy/food intolerances/typical seasoning and condiment/food avoidance, food preferences, cultural/religious food practices, type of nutrient supplements prescribed or self-prescribed, nutrient/drug interactions and nutrient/nutrient interactions, gastrointestinal discomforts, e.g. nausea, vomiting, heartburn, constipation, diarrhea, flatus, substance usage (alcohol, caffeine, prescription medications, over the counter drugs, illegal drugs, smoking), activity level (exercise, work, family), household routines for food purchases, meal preparation and consumption, including takeout food, cooking and refrigeration facilities.

Review of INFANT'S current nutritional status and needs, linkage with WIC and pediatric care infant feeding, method(s) of feeding and specifics of implementing method(s) e.g. frequency of feedings, food intake (including bottle contents) feeding positions, person(s) responsible for feedings, any problems, mother's reactions to method and feeding, infant's reactions and health indicators, household's member's responsibilities and reactions to feeding, advice, myths, information, and support from family/friends, nursing bottle mouth and fluoridation supplementation; and review, completion and CLOSE of the plan of care.

Social/Psychological

This postpartum activity shall include but not be limited to:

Review of other postpartum assessment and patient record concerning pregnancy, labor, delivery, postpartum course and infant's health; client's perception of her IMMEDIATE needs; client's perception of other needs; relationship of mother and baby; assessment of mother/infant interaction including emotional and verbal responsivity of mother and realistic expectations toward infant and signs of postpartum depression; family/household acceptance of baby and other family household dynamics; mother's perception of: father's acceptance of infant, siblings reactions to infant, reactions of other household members and close family to infant, impact of infant on mother/father relationship, impact of infant on mother/sibling relationship, views of infant care and rearing in her family and household; mother's goals/needs; general coping/emotional status; school/work (including childcare arrangements); identification of need for additional social and psychological services e.g. parenting education and support, infant equipment and supplies, financial assistance, food, clothing, housing, utilities, transportation, mental health services, drug or alcohol rehabilitation, AIDS counseling and support systems, other; referral for identified need; and review, completion and CLOSE of the plan of care.

Home Visit

This postpartum activity shall include but not be limited to:

Providing or arrangement for a postpartum home visit for preventive health care, high risk care, or skilled nursing care where it is determined that visit would be effective based on the clinical judgement of the case coordinator in conjunction with the medical care provider and other appropriate clinicians.

If the patient is receiving the necessary services in her home from another agency, the case coordinator may substitute those services for the required home visit. The case coordinator shall then coordinate services with the other agency and document the information in the patient's record.

Patients shall be identified as needing high risk care for the purpose of determining a postpartum home visit based on the following criteria:

> Patients IDENTIFIED as high risk prenatally with unresolved medical, nursing, health education, nutritional, and/or social/psychological problems; patients developing risk factors AFTER delivery, or when hospital discharge e.g. postpartum infections, depression, or other crisis situations; those that maternity or nursery staff request postpartum follow-up prior to hospital discharge; patients who have infants with continuing health problems, e.g. premature delivery, very low birth weight, NICU placement, feeding problems, and/or other needs.

Patients shall be identified as needing preventive health care for the purpose of determining a postpartum home visit based on the following criteria:

> Patients who exhibit or are suspected of serious parenting inadequacies; patients who demonstrate significant difficulty understanding and following instructions and/or linking with needed services.

HEALTHSTART EVALUATION, MONITORING, AND QUALITY ASSURANCE

OVERVIEW

The purposes of the evaluation are twofold:

1) to determine, both on a short-term and long-term basis: how successful the state has been in providing the program to the population of pregnant women and children up to the age of two who are eligible for Medicaid benefits; whether providers are delivering the services that they have agreed to provide; what the barriers are in delivering the HealthStart comprehensive services; and for those who receive services in the HealthStart program, whether the program is or is not effective.

2) To use information, as it is acquired through evaluation activities to reinforce aspects of the comprehensive maternity services that are functioning well; and correct problems that are hampering the achievement of program goals.

Together, monitoring and quality assurance make up the process component of the evaluation. Through the monitoring function the program's progress, strengths, and weaknesses will be assessed. This information will be used to address problems in program operations. The majority of information will be obtained from routinely collected sources of data, e.g. Medicaid eligibility, claims and encounter data, the electronic birth certificate (EBC) and the HealthStart Maternity Services Summary Data Form (MSSD), etc.

Through the quality assurance function direct training of providers, review with feedback, programmatic modifications, and retraining of personnel involved with HealthStart will be conducted. Due to the interactive nature of the quality assurance function, the majority of the activities will take place at HealthStart provider sites and regional meetings.

The long-range outcome component of the evaluation will focus on determining whether, and to what extent, the program has had an impact on improving both access to services and health outcomes. Measures include but are not limited to trends in the timeliness of prenatal care, the percent of low birthweight and very low birthweight infants, the number of days of care provided to infants in neonatal intensive care units, the infant mortality rate, the frequency of emergency room visits for child health problems, the immunization status of children enrolled in the program, the rehospitalization of children, and the cost effectiveness of the program. These represent some examples of appropriate outcome indicators of program performance that will be used. Much of this information will be obtained from the linkage of vital statistics data (linked-birth and death and fetal death records), Medicaid eligibility, claims data and encounter data, hospital data, and the HealthStart MSSD form.

To evaluate the HealthStart comprehensive maternity services, a quasi-experimental research design will be used. The research will be both cross-sectional, enabling snapshot examinations of a cohort of clients or providers at given points in time, (e.g. percent of pregnant women receiving first trimester prenatal care in 1985, 1986, 1987, 1988, 1989, etc.), and longitudinal, allowing follow-up of clients and providers (e.g. onset of prenatal care through birth and infant outcomes and linkage of children with pediatric providers).

The study population will include pregnant women and children up to the age of two who are residents of the State of New Jersey. In general, comparisons will be made between low income pregnant women and children who are at or below 185% of the Federal poverty who receive HealthStart comprehensive services. Trends in health outcomes will be made among all pregnant women, infants, and children up to the age of two in the State of New Jersey. This would include those who were Medicaid-HealthStart, Medicaid non-HealthStart, and non-Medicaid clients. The effectiveness of HealthStart services under the managed care system will also be evaluated. This will be done by comparing outcomes of those who receive HealthStart services through a managed care provider with the outcomes of those who did not.

Providers will be most directly involved with the process component of the evaluation. Though monitoring and quality assurance activities will be conducted for both pediatric and comprehensive maternity care services, the emphasis of the activities are somewhat different.

EVALUATION ACTIVITIES

Collection:

Analysis of data includes the areas of eligibility, reimbursement, provider agreements, specific service arrangements, client utilization of services, content of services delivered, barriers to service delivery, and client outcomes at the termination of service delivery.
These areas will be analyzed on an annual basis. For years in which data are available, trends will be examined prior to program start-up, at program start-up, and yearly thereafter. In general, the data will be analyzed in the aggregate by provider site, county, major municipality, and/or state totals.

The "source" areas for the data are:

Eligibility:	Department of Human Services/Medicaid eligibility files (both presumptive and standard).
Reimbursement:	Medicaid claims files (HCFA 1500; New Jersey 1500 (electronic only); MC 19) and Managed care capatation encounter data.
Provider participation:	Department of Health and Senior Services Comprehensive Maternity Care and Pediatric Provider Applications, and Certificates; Department of Human Services Medicaid claims and encounter data and contracting HMO's for the Managed Care services
Client utilization of services:	Department of Human Services/Medicaid claims, Department of Health and Senior Services inpatient hospital (UB 92 claims) HealthStart Maternity Services Summary Data and MC19 claims files and Medicaid Managed Care data.

Content of services delivered:	HealthStart Maternity Services Summary Data; Department of Human Services/Medicaid claims and eligibility data; Department of Health and Senior Services Hospital Discharge, UB files and Medicaid Managed data.
Barriers to service delivery:	HealthStart Maternity Services Summary Data, staff=s site visits reports and Medicaid Managed Care focus reports.
Client outcomes at termination of services:	HealthStart Maternity Services Summary Data, Department of Health and Senior Services vital statistics data (linked birth-death and fetal death records) linked with Department of Health Hospital Discharge Data, and with Medicaid eligibility, claims and encounter data.

Monitoring Activities:

Random site visits will be conducted by the New Jersey Department of Health and Senior Services HealthStart staff and may include peer consultants, (i.e. other HealthStart providers or colleagues). The site visit will be a comprehensive review of HealthStart activities, with feedback, of both prior and current HealthStart services provided. The following activities will be included:

- Review of both general and HealthStart-specific agency policies, procedures, and other administrative aspects of service delivery within the agency;

- Observation of clinic/office visits which may include physical examinations, patient care consultations on new or problem clients, sessions on nutrition, health education, social/psychological, case coordination or other aspects of HealthStart comprehensive services;

- Interviews with clients in terms of their participation in and satisfaction with HealthStart services;

- Audits on a random sample of clients= charts using an established protocol. (This will include all areas of HealthStart comprehensive maternity care services, (e.g. medical, case coordination, nutrition, social/psychological, health education, home visits, assessments, follow-up, referral, plan of care, etc.).

- Interviews and discussions with staff which cover strengths, weaknesses, and barriers to delivery of services to clients, and provide suggestions for overcoming obstacles in delivering HealthStart comprehensive services to clients.

- Written review of the organization, delivery, progress, and overall ability of the site in delivering HealthStart comprehensive maternity care services will be completed after a site visit by the DHSS HealthStart staff.

Self-audit:

This quality assurance mechanism is recommended rather than a mandatory activity. However, it will be required for those sites from which a number of clients have been identified as having unmet health care needs. It will be used as one of the methods to assist the sites to improve their delivery of HealthStart services.

Self-audit consists of a review of charts, on a monthly basis, by members of the comprehensive maternity care sites= HealthStart team, according to an established protocol. Among the recommendations are the following:

- A minimum of 5 percent of current, HealthStart client charts should be reviewed on a monthly basis for completeness and accuracy;

- The review should cover all aspects of service delivery as defined in the HealthStart standards and guidelines; it also should include mechanisms for feedback to providers responsible for clients whose charts were reviewed, recommended actions to improve content/service delivery, and follow-up on improvements in the content of medical records;

- The review should include charts for both new and previously enrolled clients;

- A staff member who audits/reviews the charts should provide the staff member responsible for the clients with feedback about the quality and completeness of the clients= records;

- A log containing the completed review protocols on the audited charts should be maintained at the HealthStart site; this should include strengths and deficiencies identified, actions taken, and completeness of records at follow-up review.

Technical Assistance:

For sites that are currently HealthStart comprehensive maternity care providers, every effort will be made to assist in working through problematic aspects of service delivery. Technical assistance may be given at the site visits or at other times, depending on providers need and availability of the Department of Health and Senior Services HealthStart staff and consultants. The need for assistance may be identified either by the provider or by DHSS\HealthStart staff.

Certification, Renewal of certification, and Decertification Procedures:

Certification: This includes the decision-making process to be used to determine which providers are qualified to deliver HealthStart comprehensive services. It begins with the receipt and review of applications for comprehensive maternity care services and may involve telephone calls and/or site visits for clarification of information before final decisions are made.

Renewal of certification: This may/may not involve the same process depending upon the decision making process of DHSS HealthStart staff.

All provider certificates will be renewed every 18 months.

Decertification: This includes the decision-making process to be used to determine infractions leading to loss of the privilege of delivering HealthStart comprehensive maternity services.

Outcome Evaluation Activities:

Evaluation of the health support activities, maternal and infant health outcomes will be conducted by the DHSS Maternal and Child Health Epidemiology staff. Findings will be reported and shared with HealthStart providers.

A. 1985 through program start-up and subsequent years:

Assessment of annual trends (pre/post HealthStart comparisons), for state, counties, and major municipalities of New Jersey will be made. Outcomes to be examined include but are not limited to the following:

- Percent low birthweight and very low birthweight infants overall and by client characteristics, location in the state, etc.;
- Birthweight-specific mortality (infant, perinatal, neonatal, postneonatal) overall and by client characteristics, location in the state.

B. Outcome comparisons by year:

Comparisons will be made of HealthStart Medicaid, non-HealthStart Medicaid, and all other non-Medicaid clients. Department of Health and Senior Services vital statistics, matched birth and death files linked to DHSS Hospital Discharge UB files, Department of Human Services Medicaid eligibility, claims and encounter files. The comparisons will be analyzed for the state overall, and by client characteristics, county and municipality of residence and services, etc. Outcomes to be examined with these data include, but are not limited to the following:

- Birthweight-specific mortality (infant, perinatal, neonatal, postneonatal, and early childhood);
- Birthweight-specific length of stay at birth and use of neonatal intensive care units;
- Birthweight-specific rehospitalizations in the first and second years of life;
- Emergency room use in the first and second years of life;
- Cost effectiveness of the HealthStart comprehensive maternity care program.

APPENDIXES

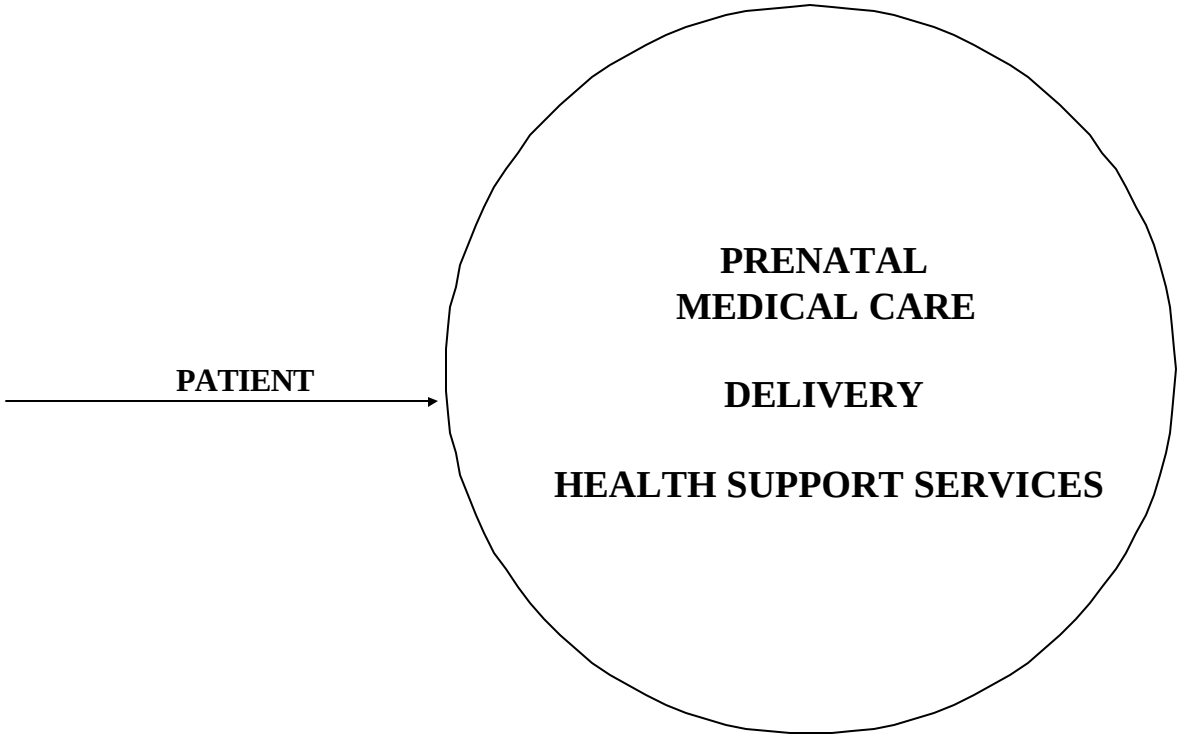
APPENDIX

1. Comprehensive Organizational Structure Models.
2. Obstetrical Services Risk Assessment Tool Sample.
3. Plan of Care Sample Tool.
4. Health Education Curriculum Guide Sample.
5. Health Education Instruction Check List Sample Tool.
6. Case Coordinator Activities.
7. Health Education Services.
8. Nutrition Services.
9. Social Psychological Services.
10. Patient Rights Responsibilities.
11. Postpartum Health Support Service/Preventive Health Care Contact Tool.
12. Release Of Information Consent Form Sample.
13. New Jersey Department of Health and Senior Services HIV “REQUIRED” Consent Form.
14. Presumptive Eligibility (PE) FD 334 revised 5/94.
15. WIC HealthStart Forms Number H4383 “HS-8 3/95”.
16. Weight Chart Form Number H4388 “HS-7 4/95”.
17. Recertification Forms (3 Pages “HS-12”, 1 Page “HS-9”).
18. Health Support Reimbursement Rates.
19. Obstetrical Care Reimbursement Rates.

APPENDIX 1

MODEL 1: COMPREHENSIVE MATERNITY CARE - ONE PROVIDER

SINGLE SITE MODEL

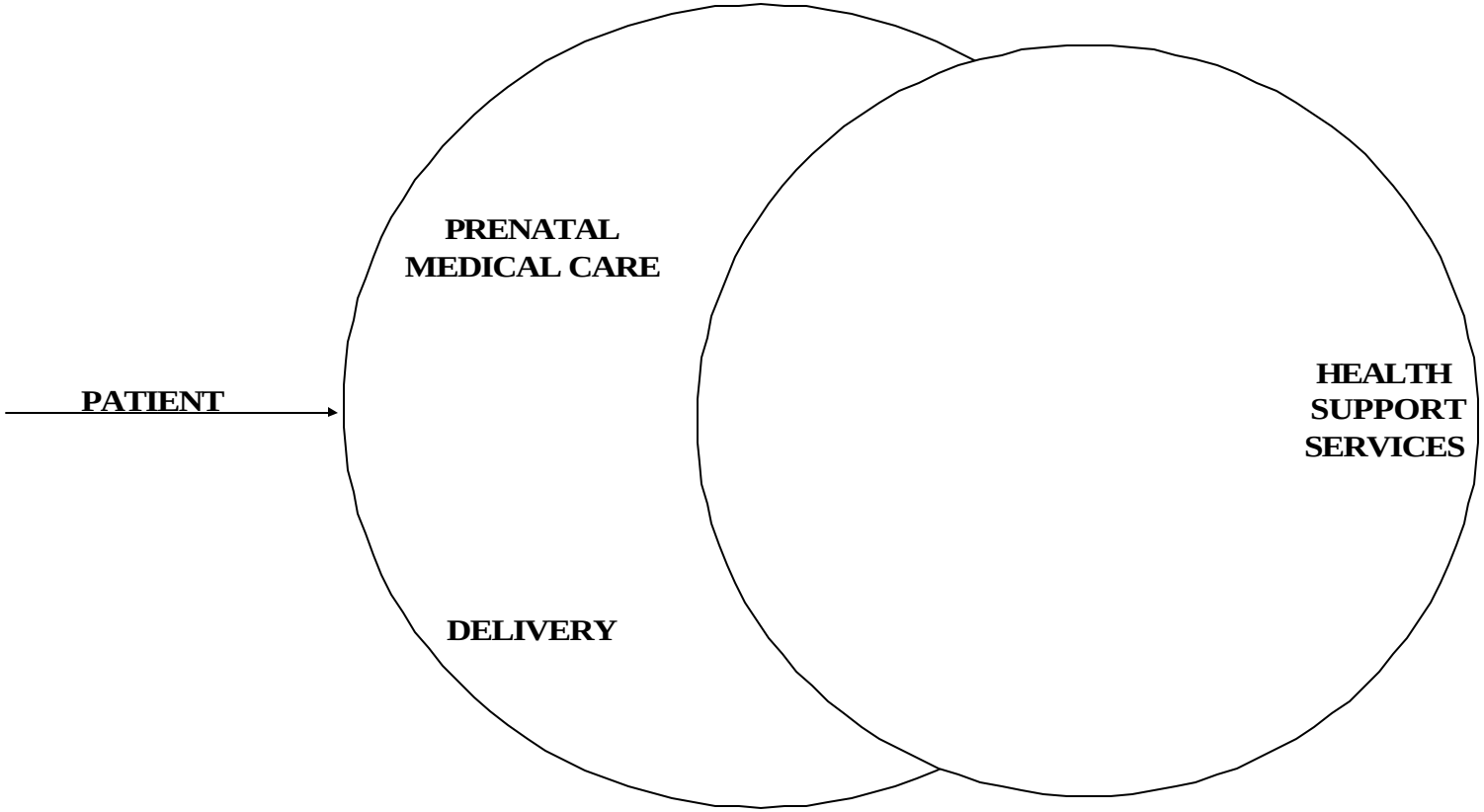


One provider provides the medical and health support services. This is the basic Model involving one provider who delivers the entire maternity care services package. This provider can be agency based or private practiced-based.

APPENDIX 1A

MODEL 2: TWO (2) PROVIDERS AGREES TO JOINTLY PROVIDE COMPREHENSIVE MATERNITY CARE SERVICES

LINKAGE MODEL

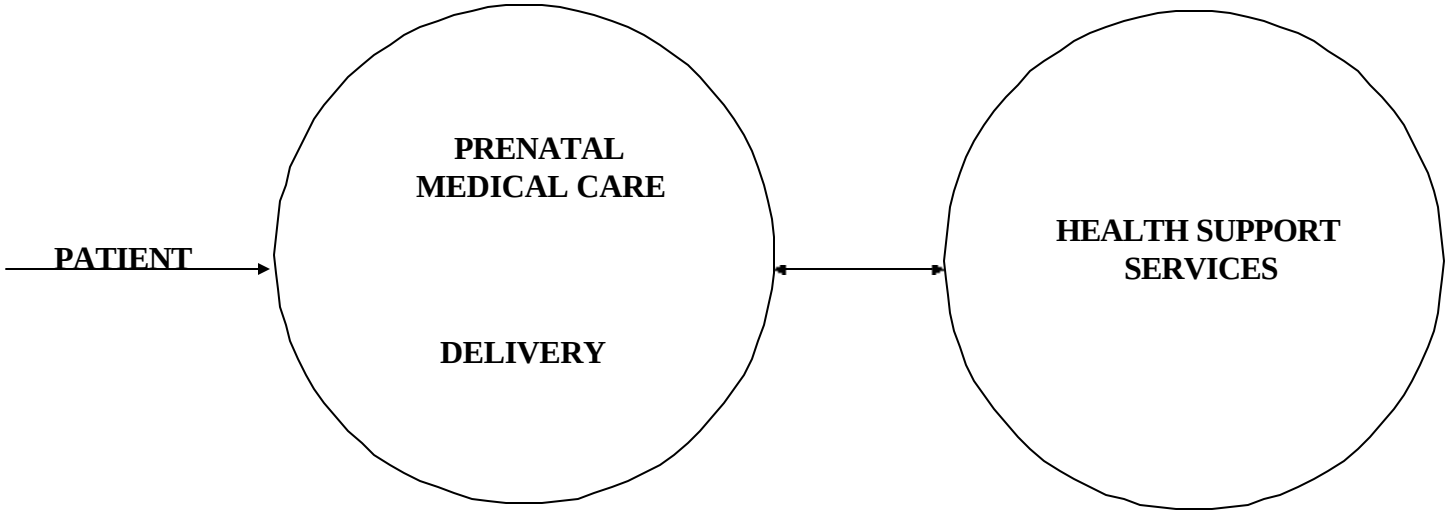


One provider agrees to provide the medical component and the other provides the health support services component. For example, a private practice (physician, certified nurse midwife, nurse practitioner or a group of practitioners) may provide the medical component at one site accessible to the patient population, and the health support services may be provided at another site such as a hospital outpatient clinic, local health department, community health center, health maintenance organization.

APPENDIX 1B

MODEL 3: ONE PROVIDER WITH AGREEMENT FOR REFERRAL

REFERRAL MODEL

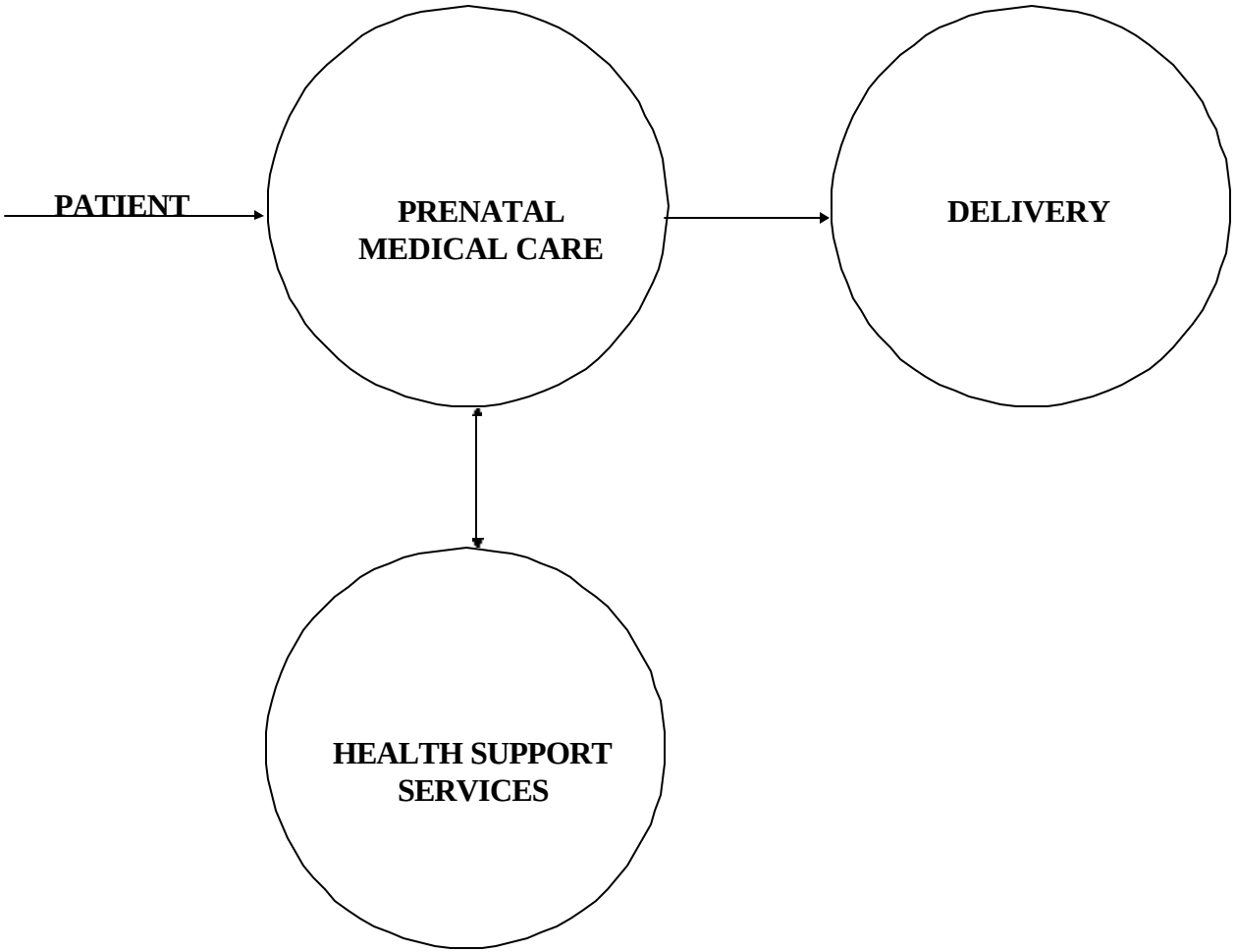


A provider refers to another provider for provision of either the medical component or the health support services component. All providers must be recognized and approved Medicaid providers in New Jersey.

APPENDIX 1C

MODEL 4: ONE PROVIDER WITH MULTIPLE REFERRAL AGREEMENTS

MULTIPLE REFERRAL MODEL

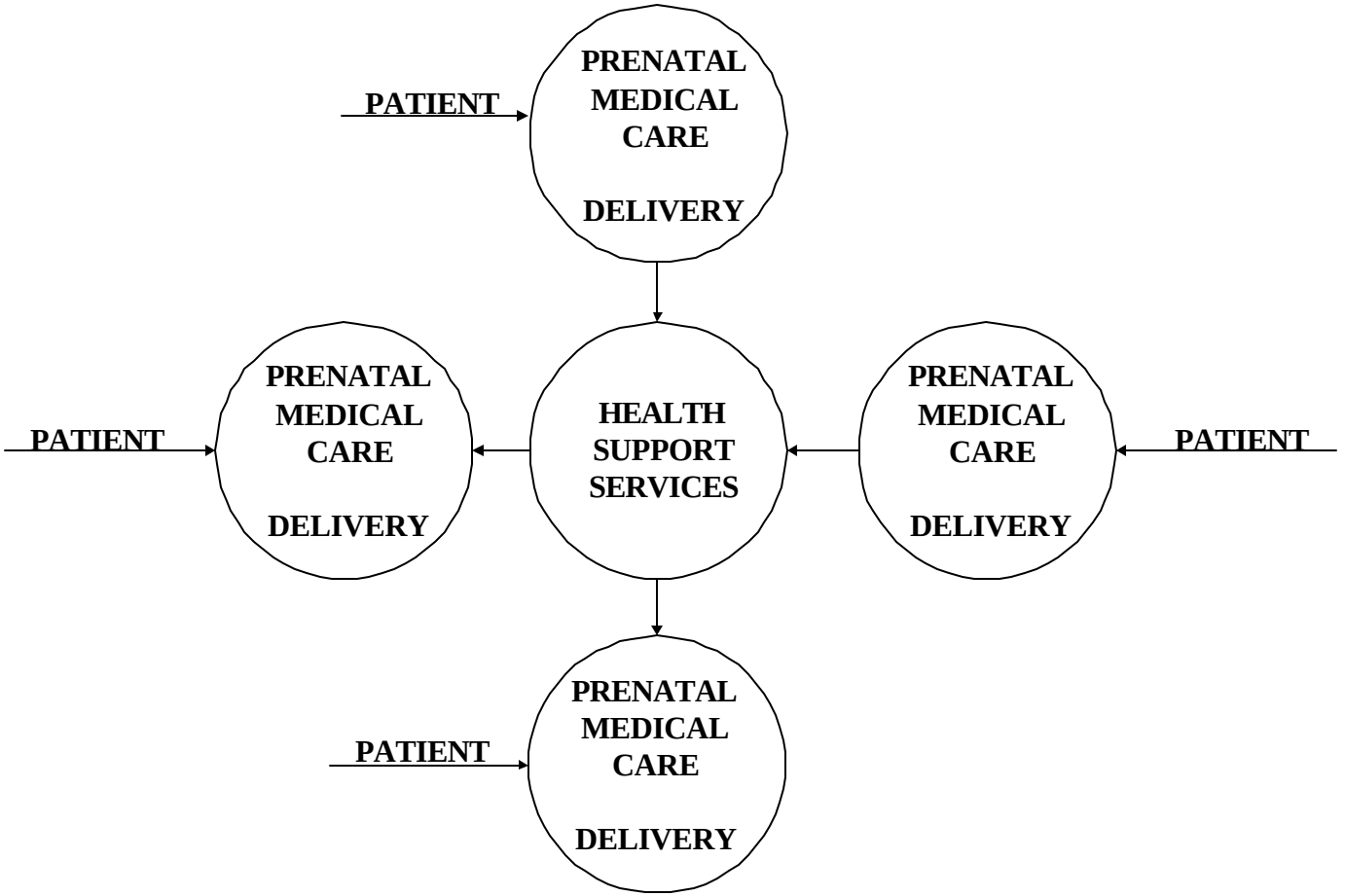


This is a combination of Models 1, 2, 3 and hospital of delivery services and health support services. The difference is that the medical care provider for prenatal care services is entirely different than one providing the delivery service. For example, a family practice physician may provide prenatal care and refer for health support services. The obstetrical care provider for the delivery may be a physician (house resident covering, an attending, and/or on-call physician) or a certified nurse midwife of the hospital generally, but not necessarily, used for delivery.

APPENDIX 1D

MODEL 5: CORE REFERRAL PROVIDER

MULTIPLE PROVIDER REFERRAL MODEL



Providers of both prenatal medical care and delivery services refer to one specific provider for health support services.

APPENDIX 2

OBSTETRICAL SERVICES						
Age	**OB/Index**	**Gravida**	**Term**	**Premi**	**Ab-ECT**	**Living**
LMP	**EDC**		**Corrected EDC**			

RISK ASSESSMENT

Patient May Be At Increased Risk For

9 Early Pregnancy Loss	9 PIH/Preeclampsia
9 Fetal Genetic Abn	9 Post-term Pregnancy
9 Fetal Structural Abn	9 Medical Complications
9 Gestational Diabetes	9 Surgical Complications
9 Maternal/Fetal Infection	9 Management Plan Conflict
9 Isoimmunization	9 Emotional Difficulty
9 Size-Date Discrepancy	9 Labor/Delivery Difficulty
9 IUGR	9 Parenting Difficulty
9 Preterm Labor/Delivery	9 OTHER

9 **PATIENT NOT AT INCREASE RISK AT INITIAL ASSESSMENT**

Signature-Date

RISK ASSESSMENT UPDATES (as indicated)

Date	GA	Signature	Date	GA	Signature

SAMPLE **SAMPLE** **SAMPLE**

PLAN OF CARE

CASE COORDINATOR: Mary A. Lawrence, RN
10/21/93

PATIENT: Mary A. Lawrence - EDC 1/12/95

Problem	Goal	Intervention/Responsible Person	Outcome
10/20/93 Poor Weight Gain	Increase weight to ____ lbs. by 6 months of pregnancy	Provide Specialized Nut Ed. M.L. RD Monitor Med. Report. J.V. MD see Nut. notes of 10/20/93	10/22/93 enrolled in WIC program 10/22/93 kept Nut. appointment 12/10/93 what was approp. for gest. age and ht.
10/20/93 Substance Abuse	Refrain from chemical use during this pregnancy	Education re: substance use (see HE and SW counseling noted) Blood and urine test ordered	Attends counseling sessions as planned, follow maintenance program as planned Blood/urine completed 10/15/93 Refer to CAC
No Problem this trimester (Date)			

***This is a sample Plan of Care**

APPENDIX 4

Health Education Curriculum *(all topics listed should be covered with modifications depending on the timing of the patient's entry into prenatal care.)*

First Trimester

Normal physical and emotional changes during pregnancy

Fetal growth and development

Normal discomforts during pregnancy, such as nausea, breast changes, frequent urination, tiredness

Examples of warning signs, such as vaginal bleeding heavy discharge painful urination, frequent headaches, blurred vision, signs and symptoms of preterm labor

Personal hygiene care including perineal care

Level of activity, such as continuing work and/or education, sexual activity, exercise, and rest

Lifestyle habits, including car safety and avoidance of alcohol, caffeine, tobacco, illegal drugs, and self-prescribed medications

Possible occupational and environmental hazards, such as toxoplasmosis, rubella, x-ray, chemicals

Need for continuing medical and dental care: for minor illnesses and for pre-existing major illnesses, such as diabetes, hypertension

Second Trimester

Readiness for childbirth preparation: including the concept of prepared childbirth, birth partners, identifying tension/stress, exercises for relaxation

Normal physical and emotional changes during pregnancy

Fetal growth and development

Normal discomforts of pregnancy, such as disrupted sleep patterns, weight gain/loss, muscle cramps, constipation, heartburn, lower abdominal pain

Examples of warning signs, such as: vaginal bleeding, heavy discharge, painful urination, frequent headaches, blurred vision, signs and symptoms of preterm labor, absence of fetal activity

Personal hygiene care including perineal care

Level of activity, including continuing work and/or school, sexual activity, exercise and rest

Lifestyle habits, including car safety and avoidance of alcohol, caffeine, tobacco, illegal drugs, self-prescribed medications

Possible occupational and environmental hazards, such as toxoplasmosis, rubella, x-ray, chemicals

Need for continuing medical and dental care

Third Trimester

Child birth education course including:

- Labor process, including signs of onset of labor (2-4 weeks before, 2-3 days before, 3 cardinal signs), vaginal delivery and cesarean section
- Management of labor, including prepared childbirth methods, medications, and different types of anesthesia/analgesia during delivery
- Visit to hospital where delivery is to be performed

Preparation for hospital admission, including care for older children during hospital stay, hospital routine, what to take to the hospital, and planning for the trip home

Newborn needs and development, including infant crying, sleeping patterns, eating patterns, pediatric care, circumcision, routine newborn screening tests

Preparations for the basic care of the infant including bathing, layette, car seat

Preparation of the family/household for the infant

Continuing medical care, including the importance of the postpartum visit
Future family planning service needs

Normal physical and emotional changes during pregnancy

Fetal growth and development

Normal discomforts during pregnancy, such as disrupted sleep patterns, weight gain, muscle cramps, constipation, heartburn, lower abdominal or back pain, tiredness

Examples of warning signs such as signs and symptoms of preterm labor, frequent headaches, blurred vision, painful urination, heavy discharge, absence of fetal activity

Level of activity, such as continuing work and/or education, sexual activity, exercise, and rest

Lifestyle habits, including car safety and avoidance of alcohol, caffeine, tobacco, illegal drugs and self-prescribed medications

Postpartum

Review of labor and delivery

Normal physical and emotional changes after the birth, including adjustments to the role of mother, postpartum depression, physical changes of the puerperium, and resumption of menstrual cycle

APPENDIX 4

Normal discomforts of the mother after the birth

Level of activity after giving birth, including postpartum sexual activity

Lifestyle habits, including avoidance of alcohol, caffeine, tobacco, illegal drugs, and self-prescribed medication

Future family planning information and services

Infant growth and development during the first three months of life

Basic care of the infant including feeding, bathing/diapering, safety, sleeping

Adjustment of the family/household to the new infant

Examples of warning signs for mother and infant which need medical attention

Need for continuing medical care for mother and infant including pediatric care, care of circumcision, prescribed medications

APPENDIX 5

SAMPLE **SAMPLE** **SAMPLE**

HEALTH EDUCATION NEEDS AND INSTRUCTION CHECKLIST					
Subjects	**Immediate or Strong Interest**	**First Trimester**	**Second Trimester**	**Third Trimester**	**Postpartum**
	(Check line below if patient emphasized during initial assessment)	(Enter date below when instruction is completed)			
Normal physical and emotional changes during pregnancy/after birth	_____	9	9	9	9
Fetal/infant growth and development	_____	9	9	9	9
Normal discomfort during pregnancy/after birth	_____	9	9	9	9
Personal hygiene	_____	9	9		
Level of activity (Sex, exercise, work)	_____	9	9	9	9
Lifestyle habits (smoking, drugs, alcohol)	_____	9	9	9	9
Occupational/environmental hazards	_____	9	9		
Need for continuing medical/dental care for mother and baby	_____	9	9		
Childbirth preparation	_____		9		9
Childbirth education course	_____				9

SAMPLE **SAMPLE** **SAMPLE**

HEALTH EDUCATION NEEDS AND INSTRUCTION CHECKLIST (Continued)

Subjects	Immediate or Strong Interest	First Trimester	Second Trimester	Third Trimester	Postpartum
	(Check line below if patient emphasized during initial assessment)	(Enter date below when instruction is completed)			
Preparation for Hospital Admission	_____			9	
Newborn Needs and Development	_____			9	
Preparation for Basic Care of Infant	_____			9	
Preparation of Family/Household for Infant	_____			9	
Importance of Postpartum Visit	_____			9	
Future Family Planning	_____			9	9
Review of Labor and Delivery	_____				9
Basic Care of Infant	_____				
Adjustment of Family/Household to Infant	_____			9	

Comments/Questions:

_____

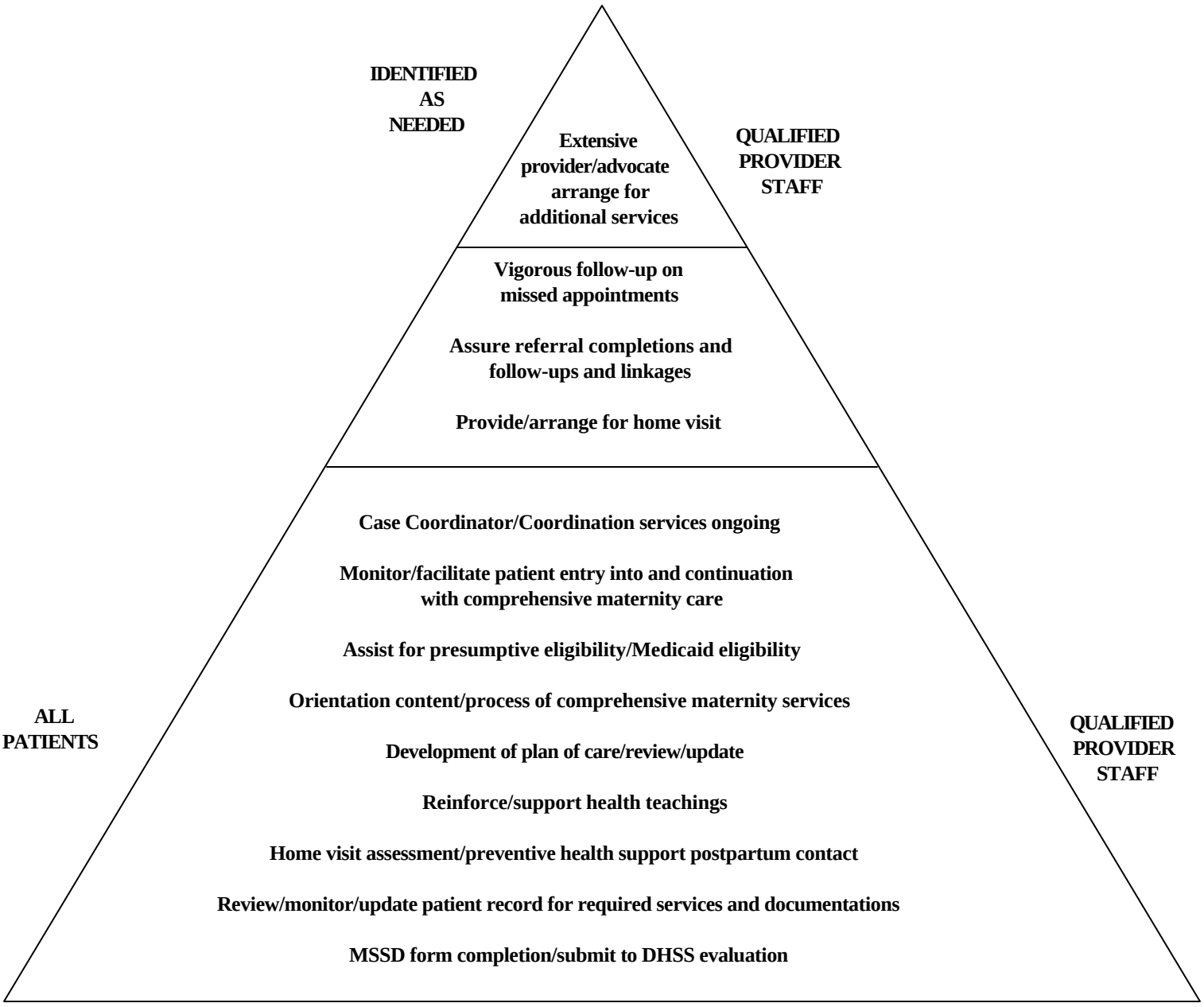
_____

_____

_____

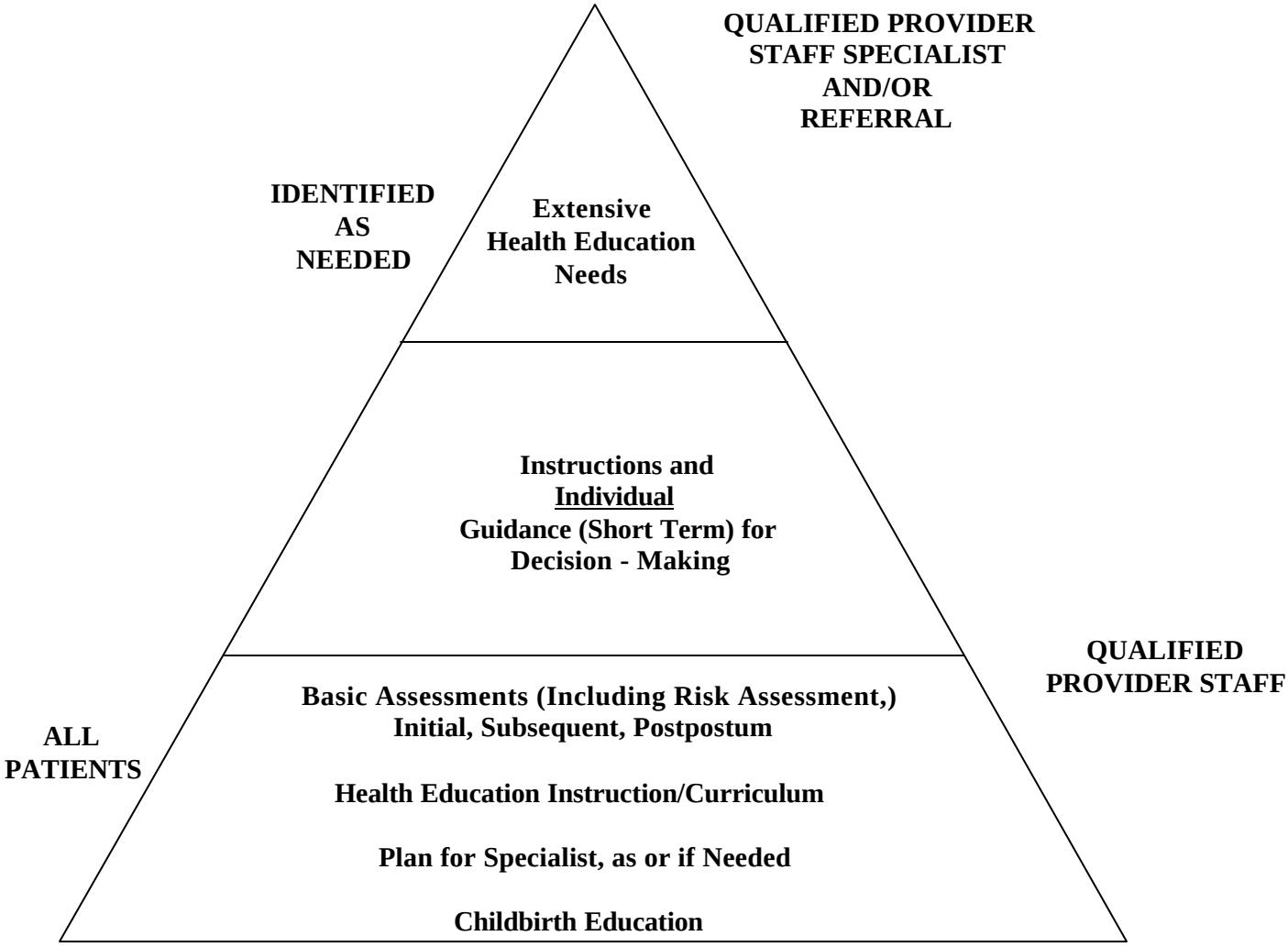
APPENDIX 6

CASE COORDINATION SERVICES



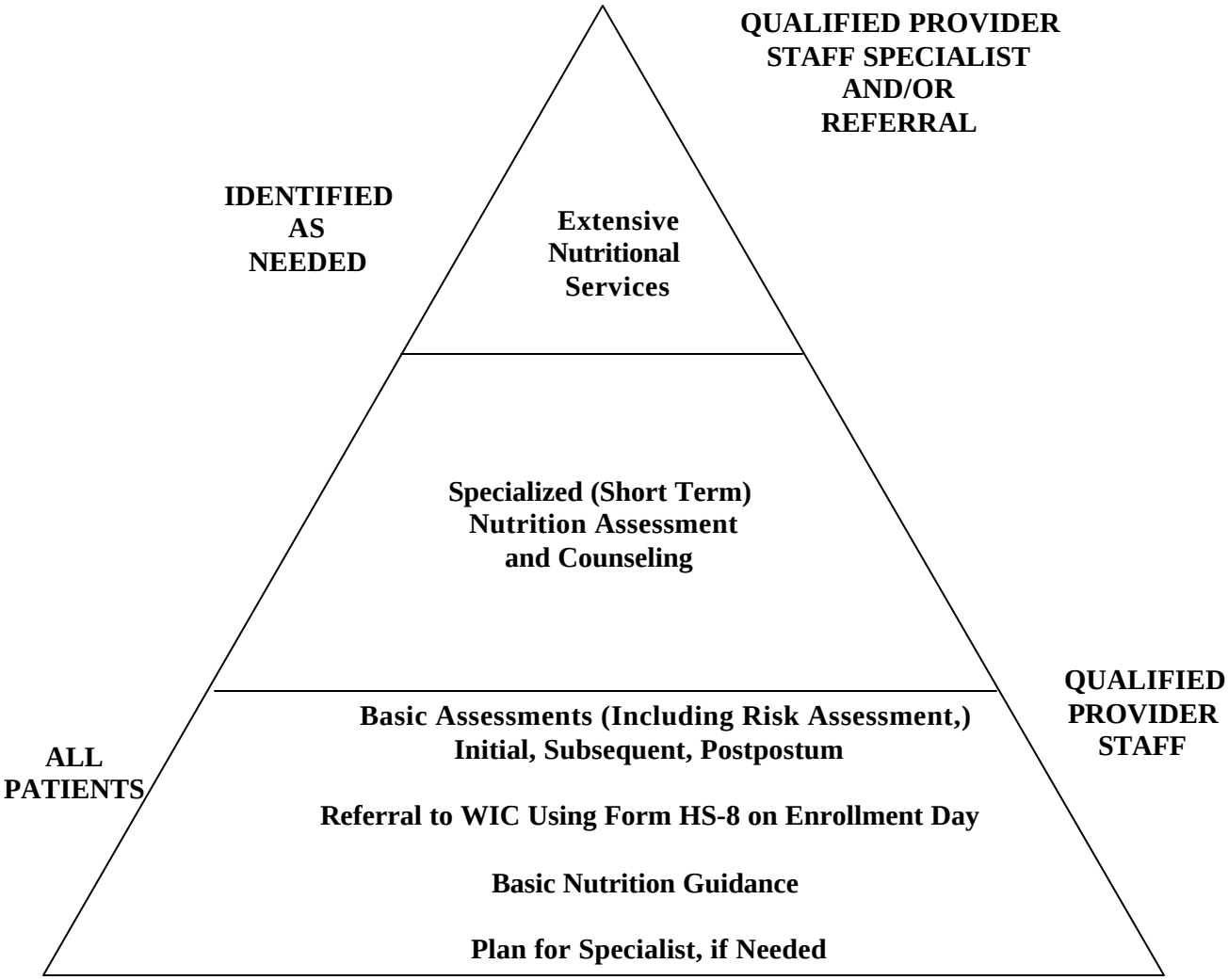
APPENDIX 7

HEALTH EDUCATION SERVICES



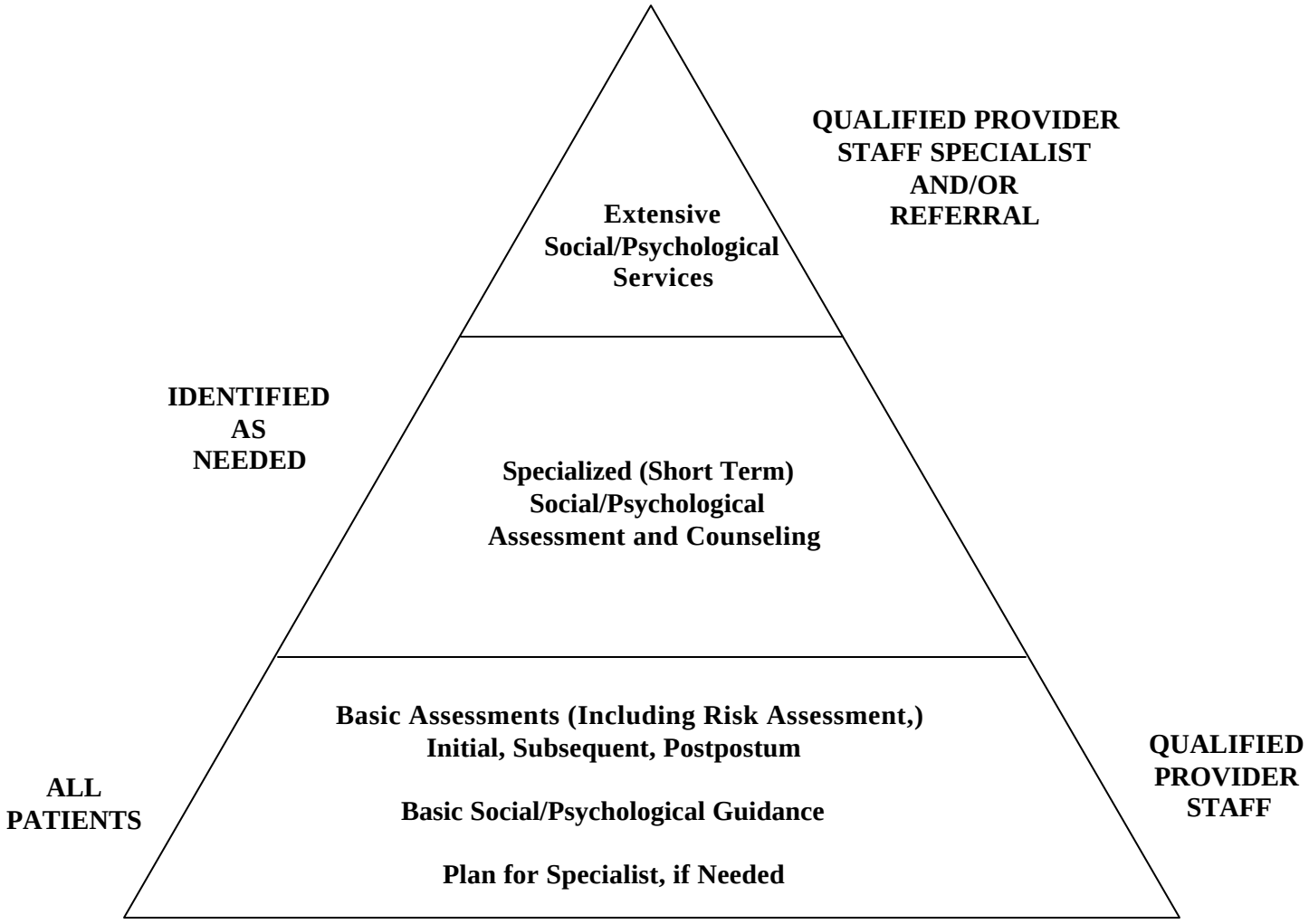
APPENDIX 8

NUTRITION SERVICES



APPENDIX 9

SOCIAL PSYCHOLOGICAL SERVICES



APPENDIX 10

SAMPLE **SAMPLE**

MATERNITY CARE PATIENTS RIGHTS AND RESPONSIBILITIES[1]

Rights:

- To be treated with dignity and respect.
- To maintain your privacy and confidentiality.
- To receive explanations about any tests or clinical procedures and answers to any questions you have.
- To receive education and counseling.
- To review the medical record with the medical care professional providing treatment.
- To consent or refuse any care or treatment.
- To participate in making any plans and decisions about your care during pregnancy, labor and delivery and the postpartum period.

Responsibilities:

- To be honest about your medical history and lifestyle which may affect you or your unborn baby's health.
- To ask questions whenever you do not understand.
- To follow health advice and instructions.
- To keep appointments and complete referrals.
- To report any changes in your health.

[1]The Comprehensive Perinatal Services Program, California Department of Health Services, March, 1987

APPENDIX 11

SAMPLE

AGENCY_____

POSTPARTUM HEALTH SUPPORT SERVICES/PREVENTIVE HEALTH CARE CONTACT

Date _____
Patient=s Name _____ Problems in Hospital _____
Baby=s Name _____ Problems in Hospital _____
Birth Date _____ Birth Weight _____
Discharge Date _____ Discharge Weight _____
Length _____ Head Circumference_____
Gestation _____ Apgar Score _____

How does your baby feed? Breast " Bottle "
How often? _____ Any problems? _____
_____
How does your baby soothe or clam itself? _____
How has your baby changed since birth? _____
_____
Does your baby sleep a lot? _____
Who is your baby=s health care provider? _____
When is (or was) the first appointment? _____
Were there any problems? _____
_____
Do you have any special questions/concerns about yourself, your baby, father of baby, siblings, or other household members? _____
_____
_____
Mother=s Goals/Needs (i.e. finance, emotional, food, housing, clothing, etc.)_____
_____
_____
Referral for identified needs, as appropriate. _____
_____
_____
Plan of Care _____ Completed _____ Reviewed _____
_____
_____
Nurse Signature/Case Coordinator _____ Date _____
Social Worker _____ Date _____
Other _____ Date _____
Health Education/See Health Education Checksheet
Signature _____ Date _____
Nutrition/See HealthStart/WIC Form
Signature _____ Date _____

6 Week Doctor Appointment Date _____ Yes " No "
Family Planning Appointment Date _____ Yes " No "
WIC Appointment Date _____ Yes " No "

APPENDIX 12

New Jersey State Department of Health and Senior Services
HealthStart Program

RELEASE OF INFORMATION

I authorize _____ (agency name) _____ to release any medical and other information about me to the State Department of Health and Senior Services which is needed for the HealthStart program for evaluation under Statute P11987 c.115, and NJAC 10:54 requiring the Department of Health and Senior Services to collect these data to perform the evaluation of the HealthStart program.

I know that the disclosure of my Social Security Number is voluntary and will be kept in strict confidentiality. It will be used only for purposes of evaluation and research by the Department.

Signed _____ Date _____

APPENDIX 13

New Jersey Department of Health and Senior Services

Name: _____

In accordance with Chapter 174, P.L. 1995:

I acknowledge that _____ has counseled and provided me with:
(Name of physician or other provider)

A. Information concerning how HIV is transmitted,

B. The benefits of voluntary testing,

C. The benefits of knowing if I have HIV virus or not,

D. The treatments which are available to me and my unborn child should I test positive, and

E. That I have a right to refuse the test and I will not be denied treatment.

I have consented to be tested for infection with HIV. “

I have decided not to be tested for infection with HIV. “

This record shall be retained as a permanent part of the patient’s medical record.

_____ _____
Date Signature

_____
Witness

C

DMAHS USE ONLY		PROVIDER USE ONLY

State of New Jersey
Department of Human Services
Division of Medical Assistance and Health Services

APPENDIX 14

CERTIFICATION OF PRESUMPTIVE ELIGIBILITY

CLIENT INFORMATION:

NAME:_____ **COUNTY OF RESIDENCE:**_____
First MI Last

ADDRESS:_____ **DATE OF BIRTH:** _____/_____/_____

_____ **SOCIAL SECURITY NO.:** _____-_____-_____

TELEPHONE NO.: ( )_____ **HOUSEHOLD UNIT:** _____ **No. of persons in household. If patient is a minor, the household unit is two (the minor & unborn child). Complete and attach deeming worksheet .**

(Check appropriate boxes below:)

Marital Status: [ ] Single [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Race: [ ] White [ ] Black [ ] Native American [ ] Asian [ ] Hispanic [ ] Other

Citizenship Status: US Citizen [ ] Yes [ ] No Qualified Alien [ ] Yes [ ] No Date of Entry into US: ___/___/___

Does client have pending TANF, NJC or SSI, Medicaid Application? [ ] Yes [ ] No ***(If yes, circle program)***

Medicare Coverage: [ ] Yes [ ] No If yes, HIC Number:_____

Other Insurance Company:_____ Other Insurance Policy No.:_____

INCOME INFORMATION:

Total Household Income:	**Income**	**Frequency**	**Gross Monthly Amt.**	**Source**
Gross Earnings				
Gross Earnings				
Gross Unearned Amount				
Gross Unearned Amount				
Gross Unearned Amount				
Gross Child Support Amount				
Gross Alimony Amount				

TOTAL MONTHLY GROSS INCOME $_____

Child Care Expense Amount:_____ Weekly_____ Biweekly_____ Monthly

PREGNANCY INFORMATION:

Date of L.M.P.:_____ Pregnancy Due Date:_____

CERTIFICATION STATEMENT:

*I,*_____*attest that I have read and agree to the above statements and fully realize that the county welfare agency relies upon the truth and accuracy of my statements. I have received a copy of and understand the Patient Guidelines.*

_____ _____
Applicant Signature *Date*

I certify the above applicant is pregnant and presumptively eligible for limited Medicaid benefits in accordance with N.J.A.C. 10:72-6.1 et seq.

_____	_____	_____
Provider Agency Name	*Address*	*Telephone No.*
_____	_____	_____
Provider Signature	*Date*	*Three-Digit Provider No.*

IMPORTANT: THE ORIGINAL FORM MUST BE FORWARDED TO THE DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES, PRESUMPTIVE ELIGIBILITY UNIT, P.O. BOX 712, MAIL CODE 38, TRENTON, NEW JERSEY 08625-0712, WITHIN TWO (2) WORKING DAYS OF COMPLETION.

WHITE - DMAHS CANARY - COUNTY WELFARE AGENCY PINK - PROVIDER GOLDENROD - CLIENT

FD 334 (Rev. 10/98)

New Jersey State Department of Health
WIC / HEALTHSTART

REFERRAL/NUTRITION ASSESSMENT FOR WOMEN

Please see instructions on reverse side.

NAME OF CLIENT	TELEPHONE NUMBER	DATE OF BIRTH
		___/___/___
ADDRESS OF CLIENT	CHECK ONE: ☐ Pregnant ☐ Breastfeeding ☐ Non-Breastfeeding	

REFERRAL *(To be completed by Health Professional, including reverse side.)*

ANTHROPOMETRIC AND LABORATORY DATE (One Blood Test is Required)

First Prenatal Check-up: Date: ___/___/___ # Weeks Gestation _____ Weight (Lbs.) _____ Pre-Preg. Wt. (Lbs.) _____ Usual Wt. (Lbs.) _____

Current Check-up: Date: ___/___/___ # Weeks Gestation _____ Weight (Lbs.) _____ Height (Inches) _____

Blood Test: Date: ___/___/___ Hb (mg/dl) _____ Hct _____ % EP (ug/dl) _____ Lead _____ Other _____

MEDICAL HISTORY

Gravida _____ Para _____ Ab/Misc _____ Stillbirth _____ EDC _____ ADC _____ ☐Vag ☐"C" Section

Past Med./Surg. History _____

Current Medical Problem(s) _____

Previous Preg. Complications _____ Date Last Preg. Ended ___/___/___

Physician/Clinic _____ Phone _____

Signature of Health Professional _____ Date ___/___/___

WIC APPOINTMENT: DATE: ___/___/___ TIME: _____

ASSESSMENT *(To be completed by Client or Health Professional.)*

1. Are you taking any of the following?
   - Vitamins/Minerals ☐ Yes ☐ No Amount: _____ Type: _____
   - Iron ☐ Yes ☐ No Amount: _____ Type: _____
   - Over-the-Counter Medicines ☐ Yes ☐ No Amount: _____ Type: _____
   - Special Medicines ☐ Yes ☐ No Amount: _____ Type: _____
   - "Street" Drugs ☐ Yes ☐ No Amount: _____ Type: _____
2. How much did you smoke before you were pregnant? Amount: _____
   How much do you smoke now? Amount: _____
3. How much beer, wine cooler, or liquor do you drink per week? Amount: _____
4. Are you on a special diet now? ☐ Yes ☐ No Prior to pregnancy? ☐ Yes ☐ No
5. Are you experiencing?

Nausea	☐ Yes	☐ No	Heartburn	☐ Yes	☐ No
Frequent Vomiting	☐ Yes	☐ No	Flatus ("Gas")	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No	Dental Problems	☐ Yes	☐ No
Constipation	☐ Yes	☐ No	Bleeding Gums	☐ Yes	☐ No

6. Do you eat?

Paint Chips	☐ Yes	☐ No	Dirt	☐ Yes	☐ No
Laundry Starch	☐ Yes	☐ No	Clay	☐ Yes	☐ No
Corn Starch	☐ Yes	☐ No	Plaster	☐ Yes	☐ No
Ice	☐ Yes	☐ No	Other Cravings	☐ Yes	☐ No

7. Do you have a working?

Stove	☐ Yes	☐ No	Sink with Water Supply	☐ Yes	☐ No
Refrigerator	☐ Yes	☐ No			

8. Are you on any program?

WIC	☐ Yes	☐ No	HealthStart/	☐ Yes	☐ No
Child Support Enf.	☐ Yes	☐ No	Presumptively Eligible	☐ Yes	☐ No
Food Stamps	☐ Yes	☐ No	AFDC/Medicaid	☐ Yes	☐ No

9. How do you plan to or presently feed your baby?
   Breastmilk ☐ Yes ☐ No Formula ☐ Yes ☐ No Undecided? ☐ Yes ☐ No
10. Do you do the following daily?
    - Work ☐ Yes ☐ No Type: _____
    - Care for Children ☐ Yes ☐ No How Many: _____
    - Exercise ☐ Yes ☐ No Type: _____
11. If pregnant, how much weight (pounds) do you plan to gain? _____
12. Where do you plan to or presently take your child for medical care?

_____

New Jersey State Department of Health
WIC / HEALTHSTART

REFERRAL/NUTRITION ASSESSMENT FOR WOMEN

INSTRUCTIONS

— AGENCY USE ONLY —

Referral Section ***(Complete by Health Professional.)***

1. Fill in client's name, address, phone number, date of birth, or use addressograph stamp.
2. Check status of woman being referred.
3. Fill in data on first prenatal check-up and current check-up, if applicable.
4. One blood test is required prior to submitting this form to WIC.
   Pregnant women need blood test which was done during pregnancy.
   Postpartum women (breastfeeding and non-breastfeeding) need blood test which was done after delivery.
5. Complete Gravida, Para, Abortions, Miscarriages.
6. Fill in EDC (Estimated Date of Confinement) for prenatal clients.
7. Fill in ADC (Actual Date of Confinement), vaginal or "C" Section delivery for postpartum clients.
8. Complete past medical/surgical history based on client's record.
9. Fill in any pertinent current medical problems diagnosed.

Information in this Section should Not Include most recent pregnancy for Postpartum Women.

10. Complete previous pregnancy complications, referring to list below:
    Write approximate letter or letters on space provided.
    a. Hx of low birth weight infant(s) (< 5.5 lbs.)
    b. Hx of premature infant(s) (< 37 weeks gestation)
    c. Hx of infant(s) > 10 lbs. at birth
    d. Hx of or planned C-section
    e. Multiple pregnancy or recent multiple birth.
    f. Medical problems (e.g., diabetes, hypertension, preeclampsia, eclampsia)
    g. Disability which may compromise adequacy of diet
    h. Social or environmental condition which may compromise adequacy of diet
    i. Substance use (e.g., alcohol, drugs, cigarettes, pica)
    j. Vitamin/mineral supplement or medicine prescription
    k. Special formula prescription and medical reason for its necessity
    l. Other pertinent health/medical data
11. Fill in physician's name or clinic and phone number.
12. Signature of referring health professional IS REQUIRED, with current date.

Assessment Section / Food Frequency ***(Page 1 and 2)***

1. This section may be completed by the client or a health professional.
2. If completed by client, it must be reviewed by the health professional for accuracy and completeness. Check the appropriate answer for questions 1-18. Any reponses which do NOT meet WIC and/or HealthStart standards demand further clarification.
3. The health professional should compare the food frequency with the recommended servings needed daily for pregnant/postpartum women and formulate a nutrition plan of care accordingly.
4. The Nutrition Assessment and Plan of Care must be written according to the hospital/ HealthStart Agency/WIC State policy and procedure.
5. Upon completion of nutrition education, the health professional must circle the appropriate Nutrition Education Topics and record the date. (More topics below.) If materials are provided, write the appropriate Topic Code in the space labelled "Other".

05 - Child Nutrition	11 - Mealtime Psychology	18 - Sugar in Diet
06 - Dental Health	12 - Nutrients in WIC Foods	19 - Vitamin A in Diet
07 - Fat in Diet	15 - Salt in Diet	20 - Vitamin C in Diet
08 - Food Budget/Consumer Awareness/Meal Planning	16 - Smoking & Pregnancy	44 - No Show
	17 - Snacking	45 - Client Refused
09 - Fruit and Vegetables		

NAME AND ADDRESS OF WIC PROGRAM, HEALTHSTART AGENCY, PHYSICIAN OR CLINIC:	TELEPHONE NUMBER

New Jersey State Department of Health
WIC / HEALTHSTART

REFERRAL/NUTRITION ASSESSMENT FOR WOMEN, Continued

NAME OF CLIENT	TELEPHONE NUMBER	DATE OF BIRTH
		___/___/___

CHECK ONE:

☐ Pregnant ☐ Breastfeeding ☐ Non-Breastfeeding

13. How is your appetite? ☐ Good ☐ Fair ☐ Poor
14. Do you have any allergies/intolerances? _____
15. Who does the food shopping? _____
16. Who cooks your food? _____
17. Where do you eat most of your meals? ☐ At home ☐ Restaurant/fast foods ☐ Other, specify: _____
18. Do you avoid any food due to cultural or religious practice? ☐ Yes ☐ No
    if yes, specify: _____

FOOD FREQUENCY *(How many times do you eat the following foods?)*

FOODS	DAILY	WKLY.	MTHLY.	NEVER
EXAMPLE: Milk (whole, 2%, 1% skim)	4			
Milk (whole, 2%, 1%, skim, other)				
Cheese				
Ice Cream, Yogurt, Pudding				
Meat, Poultry, or Fish (hamburger, roast beef, steak, pork chops, ribs, ham, chicken, turkey, fish, tunafish, lamb, liver, etc.)				
Luncheon Meats, Hot Dogs, Sausage, Bacon				
Eggs				
Dry Beans, Nuts, Peanut Butter				
Orange, Grapefruit (fruit or juice), Other WIC Juices				
Dark Green or Dark Yellow Fruits and Vegetables, Cantaloupe, Nectarine, Mango, Papaya, Spinach, Greens, Broccoli, Carrots, Plantain, Pumpkin (calabaza)				

FOODS	DAILY	WKLY.	MTHLY.	NEVER
Other Fruits and Vegetables (salad, peas, string beans, apples, pears, peaches, tomato, tomato sauce, .etc.)				
Cereal (hot or cold)				
Rice, Noodles, Macaroni, Corn, Potato				
Pizza, Soup, Spaghetti, Ravioli (in can or jar)				
Bread, Toast, Crackers, Rolls, Biscuits, Bagels, Tortillas, Pancakes, Waffles, Muffins				
Fruit Drinks (Kool-aid, Hi-C, Tang, Hawaiian Punch, etc.) Malta				
Soda, Coffee, Tea, Water				
Candy, Cake, Pie, Donut, Cookies, Pastry, Gelatin Desert				
Snacking Chips, Popcorn, Pretzels				
Fast Food (french fries, etc.)				

FOR STAFF USE ONLY*

Adult Women	Servings Needed Daily** Preg/ Brstfd	Non-Brstfd	Servings Consumed
Milk Product	3+	2-3	
Meat & Subst	6+ oz.	6 oz.	
Vege-tables	4+	4	
Fruits	3+	3	
Breads & Cereals	9+	9	

NUTRITION EDUCATION TOPIC CODES

Materials Provided	Date
01-Adolescent Prenatal Nutrition	
02-Anemia/Iron	
03-Breastfeeding	
04-Calcium	
10-Infant Nutrition	
13-Postpartum Nutrition	
14-Prenatal Nutrition	
21-Weight Control	
Other _____	

NUTRITION ASSESSMENT AND PLAN OF CARE:

RISK CODE: _____

WIC FOOD PKG. CODE: _____

1 2 3 4 5 6 7 8 9

SIGNATURE _____ DATE _____

HS-8
Revised 3/95

*SEE ATTACHMENT 208J OF NJ WIC POLICY & PROCEDURE MANUAL FOR TABLE OF STANDARD SERVING SIZES FOR WOMEN
**REFERENCE: USDA, "The Food Pyramid," 1992

#H4383

New Jersey State Department of Health
WIC / HEALTHSTART

REFERRAL/NUTRITION ASSESSMENT FOR WOMEN

INSTRUCTIONS

ASSESSMENT SECTION/FOOD FREQUENCY *(Page 1 and 2)*

1. This section may be completed by the client or a health professional.
2. If completed by the client, it must be reviewed by the health professional for accuracy and completeness. Check the appropriate answer for questions 1 - 18. Any responses which do NOT meet WIC and/or HealthStart standards demand further clarification.
3. The health professional should compare the food frequency with the recommended servings needed daily for pregnant/postpartum women and formulate a nutrition plan accordingly.
4. The Nutrition Assessment and Plan of Care must be written according to the hospital/HealthStart Agency/WIC State policy and procedure.
5. Upon completion of nutrition education, the health professional must circle the appropriate Nutrition Education Topic Code and write the date education was provided.
6. Listed below are a continuation of Nutrition Education Topics. If materials are provided, write the appropriate Topic Code in the space "Other."

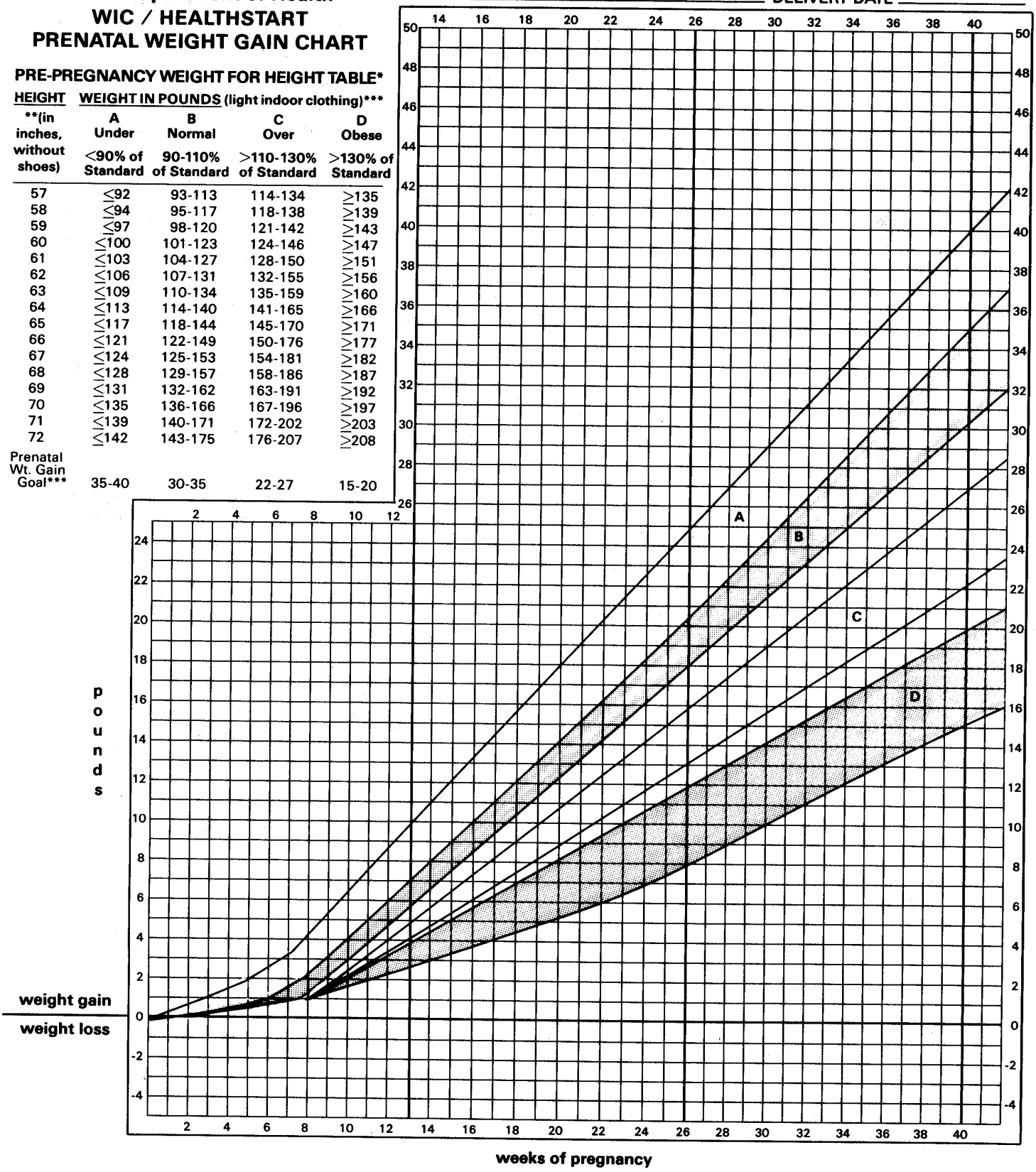
05 - Child Nutrition
06 - Dental Health
07 - Fat in the Diet
08 - Food Budgeting/Consumer Awareness/Meal Planning
09 - Fruit and Vegetables
11 - Mealtime Psychology
12 - Nutrients in WIC Foods
15 - Salt in the Diet
16 - Smoking and Pregnancy
17 - Snacking
18 - Sugar in Diet
19 - Vitamin A in Diet
20 - Vitamin C in Diet
44 - No Show
45 - Client Refused

New Jersey
State Department of Health
WIC / HEALTHSTART
PRENATAL WEIGHT GAIN CHART

NAME _____ ESTIMATED DELIVERY DATE _____

PRE-PREGNANCY WEIGHT FOR HEIGHT TABLE*

HEIGHT **(in inches, without shoes)	WEIGHT IN POUNDS (light indoor clothing)*** A Under <90% of Standard	B Normal 90-110% of Standard	C Over >110-130% of Standard	D Obese >130% of Standard
57	≤92	93-113	114-134	≥135
58	≤94	95-117	118-138	≥139
59	≤97	98-120	121-142	≥143
60	≤100	101-123	124-146	≥147
61	≤103	104-127	128-150	≥151
62	≤106	107-131	132-155	≥156
63	≤109	110-134	135-159	≥160
64	≤113	114-140	141-165	≥166
65	≤117	118-144	145-170	≥171
66	≤121	122-149	150-176	≥177
67	≤124	125-153	154-181	≥182
68	≤128	129-157	158-186	≥187
69	≤131	132-162	163-191	≥192
70	≤135	136-166	167-196	≥197
71	≤139	140-171	172-202	≥203
72	≤142	143-175	176-207	≥208
Prenatal Wt. Gain Goal***	35-40	30-35	22-27	15-20



* Add 3 pounds to the woman's weight if weighed without clothes.

** Height measurements of ≥ 1/2 inch should be rounded to the next whole inch.

*** For twin pregnancies: Normal weight women should gain 41 pounds; underweight women should gain 44 pounds.

Chart adapted with permission from the New York WIC Program.
Grid adaped from Judith Brown, Healthy Infant Outcome Project, University of Minnesota.

HS-17
Revised 4/96

— Please see reverse for instructions on completing this chart. —

#H4455

New Jersey Department of Health and Senior Services
WIC / HEALTHSTART

PRENATAL WEIGHT GAIN CHART

INSTRUCTIONS

1. Ascertain the pre-pregnancy weight of the pregnant woman by use of the Referral Form or by asking the woman to recall her weight prior to pregnancy. If possible, weigh and measure the pregnant woman. If not possible, use recent weight and height given on the Referral Form.

2. Circle both height and pre-pregnancy weight range of the pregnant woman on the Pre-pregnancy Weight for Height Table. If underweight range is circled, then Nutritional Risk Factor "07" can be used at certification. If overweight or obese range is circled, then Nutritional Risk Factor"08" can be used at certification. (See explanation of these codes in the table below.)

3. Subtract the pre-pregnancy weight from the weight at the most recent measurement. This is the weight change. A positive number indicates a gain in weight; a negative number indicates a loss of weight.

4. Calculate the number of weeks of pregnancy at the time of the weight measurement by using a gestational wheel or calculate it by using the Months to Weeks Conversion Table below.

5. Put an "X" on the chart in the location where the number of weeks of pregnancy intersects with the weight change calculated in instruction #4 above.

6. A woman at normal weight prior to pregnancy should gain 30-35 pounds (shaded area B on grid) during pregnancy. Women who are underweight, overweight, or obese prior to pregnancy should be assessed on an individual basis. Recommendations of the healthcare provider should be used, when available. It is recommended that an underweight woman gain 35-40 pounds (area A on grid), an overweight woman gain 22-27 pounds (area C on grid), and an obese woman gain 15-20 pounds (shaded area D on grid) during the entire pregnancy. Nutritional Risk Factors 04, 05, and 06 may be used at the discretion of the Competent Professional Authority (See explanation of these codes in the table below).

Nutritional Risk Factors for Women

04 Insufficient prenatal weight gain (as evidenced by weight gain chart or any weight loss or gain ≤2 lbs./month during 2nd or 3rd trimester or ≤2 lbs. during 1st trimester).

05 Irregular pattern of prenatal weight gain and loss (as evidence by weight gain chart).

06 Excessive prenatal weight gain pattern for body size (as evidence by weight gain chart or >2 lbs./week).

07 Low pre-pregnancy or postpartum weight (weight for height <90% of standard).

08 Obese or overweight pre-pregnant/postpartum women (obese = wt/ht > 120% of standard) (overweight = wt/ht > 110% of standard).

Months to Weeks Conversion Table

(Calculate from first day of last menstrual period)

1 month	=	4 weeks
2 months	=	9 weeks
3 months	=	13 weeks
4 months	=	18 weeks
5 months	=	22 weeks
6 months	=	27 weeks
7 months	=	31 weeks
8 months	=	36 weeks
9 months	=	40 weeks

New Jersey Department of Health and Senior Services
HealthStart
PO Box 364
Trenton, NJ 08625-0364

APPENDIX 17

Please Return By

COMPREHENSIVE MATERNITY CARE PROVIDERS
RECERTIFICATION SURVEY

Name of Agency	Date Certificate Expires / /	Medicaid Provider Number
Name of President/CEO	Telephone Number ( )	Medicaid Health Support Svcs. No. (Hosp-Based Only)

SECTION I – PRENATAL AND POSTPARTUM SERVICES

1. Prenatal Services Schedule (indicate hours):
   Monday _____ Thursday _____
   Tuesday _____ Friday _____
   Wednesday _____ Saturday _____
2. Prenatal Services Telephone Number: ( ) _____ - _____
3. Total Obstetrical Care Provider Hours and Days Available During Scheduled Sessions:
   Hours: _____ Days: _____
4. Do All Professionals Meet Minimum HealthStart Staffing Qualifications? ☐ Yes ☐ No
5. Are All Professionals New Jersey State Licensed? ☐ Yes ☐ No
6. Average Number of Enrollees:
   a. Scheduled Each Session: _____
   b. Seen Each Session: _____
   c. New Enrolled Each Month: _____
7. Current Number of:
   a. Prenatal Enrollees: _____
   b. Postpartum Enrollees: _____
8. Percentage of enrollees who "drop out of care:" _____ %
9. Percentage of enrollees who return for medical postpartum care: _____ %
10. Future Family Planning Provided By: ☐ Your Agency ☐ Referral
11. If by Referral, name of agency(ies) receiving referral:
    _____
12. At your agency, does the number of weeks between enrollee's first request for prenatal services and provision of the initial medical services ever exceed two (2) weeks? ☐ Yes ☐ No
    a. If Yes, explain why: _____
    _____

SECTION II – POLICY QUESTIONS

1. Is there an integrated plan of care for each enrollee that is reviewed and updated appropriately and includes ALL HealthStart components (Medical, Social/Psychological, Nutrition, Health Education)? ☐ Yes ☐ No (Explain)*
2. Is there a twenty-four (24) hour access procedure for enrollees? ☐ Yes ☐ No (Explain)*
3. Is there sufficient and appropriate documentation in the enrollees' charts for all comprehensive services provided (documentation means written, signed name, credentials, date)? ☐ Yes ☐ No (Explain)*

*Explain any "No" answers in the Comments Section.

COMPREHENSIVE MATERNITY CARE PROVIDERS
RECERTIFICATION SURVEY
(Continued)

SECTION II – POLICY QUESTIONS, CONTINUED

4. Is there a quality assessment/improvement program for the prenatal services? ☐Yes ☐No (Explain)*
5. Is there a signed agreement between your agency and WIC (for referrals using HS-8 form)? ☐Yes ☐No (Explain)*
6. Are there procedures in place for conducting uniform risk assessments, informed consent and confidentiality of records and care? ☐Yes ☐No (Explain)*

*Explain any "No" answers in the Comments Section.

SECTION III – SERVICES QUESTIONS

1. Are home visits provided/arranged:
   a. For high risk enrollees? ☐Yes ☐No (Explain)*
   b. For preventive health care enrollees? ☐Yes ☐No (Explain)*
   c. If Yes, by whom?
      ☐Your agency ☐Another agency name: _____
   d. If not provided, please explain:
      _____
2. Does your agency have any outreach program that facilitates early entry into prenatal care? ☐Yes ☐No (Explain)*
3. Is WIC on site when maternity care services are being provided ☐Yes ☐No (Explain)*
4. Is there an outstation Medicaid worker on site during maternity care services? ☐Yes ☐No
5. Is there EPSDT or HealthStart preventive pediatric care services provided by your agency? ☐Yes ☐No (Explain)*
6. Is your agency an authorized Presumptive Eligibility (PE) provider? ☐Yes ☐No
   a. If yes, name of PE contact person(s):
      _____
7. Is your agency a participating Managed Health Care provider for prenatal services? ☐Yes ☐No
   a. If yes, name(s) of the health maintenance organization (HMO):
      _____
      _____

*Explain any "No" answers in the Comments Section.

Comments regarding any aspect of HealthStart:

Completed By	Title
Signature of Unit Administrator	Date

Complete Page 3 of this Recertification Survey which is a staff roster for all obstetrical medical care and health support services staff who will provide HealthStart comprehensive maternity care services.

New Jersey Department of Health and Senior Services
HealthStart

APPENDIX 17

COMPREHENSIVE MATERNITY CARE PROVIDERS RECERTIFICATION SURVEY - STAFF ROSTER

Position	Staff/ Consult (S/C)	Name / Credentials License / Exp. Date	Hours Per Week	Hourly Breakdown					
				Medi-cal	Case Coord.	Health Educ.	Psych. Soc.	Nutr.	Other
TOTAL									

Staff or Consultant:
S = Salaried employee, paid fringe benefits, on staff
C = Paid hourly, or contract rate, not an employee, consultant

New Jersey Department of Health and Senior Services
HealthStart Program
PO Box 364
Trenton, NJ 08625-0364

APPENDIX 17

COMPREHENSIVE MATERNITY CARE CHART AUDIT

Name of Agency	Date

Patient Record Number	Birthdate / Age

Prenatal Visits This Audit

1st _____ Gestational Age (Weeks of Pregnancy) _____ EDC _____ Last _____ Total Visits _____

Code: C = Complete I - Incomplete A – Absent

C	I	A	ACCESS TO CARE
☐	☐	☐	Initial appointment within 2 weeks of request for services.
☐	☐	☐	Presumptive eligibility processing forms (FD 334 and Pregnancy Test)
☐	☐	☐	Identification of Case Coordinator
			ASSESSMENT TOOL FOR:
☐	☐	☐	Medical Risk Factors (MD)
☐	☐	☐	Nutritional (HS-8 form)
☐	☐	☐	Social-Psychological
☐	☐	☐	Health Education
			PLAN OF CARE TOOL
☐	☐	☐	Developed: Initial
☐	☐	☐	Review Update: Ongoing
			Case Conference/Consultation:
☐	☐	☐	Initial
☐	☐	☐	Ongoing
			MATERNITY MEDICAL CARE SERVICES
☐	☐	☐	Initial Prenatal Visit Content
☐	☐	☐	Risk Assessment (MD), Updates
☐	☐	☐	Subsequent Prenatal Visits
☐	☐	☐	Laboratory Results Signed by MD
☐	☐	☐	Transfer of Prenatal Records at 34th Week
☐	☐	☐	Intrapartum Services Provisions Made
☐	☐	☐	Postpartum Visit Content

C	I	A	HEALTH SUPPORT SERVICES PROVIDED
			Case Coordination Activities:
☐	☐	☐	Prenatal
☐	☐	☐	Postpartum
			Nutrition:
☐	☐	☐	Basic
☐	☐	☐	Subsequent
☐	☐	☐	Specialized (as needed)
☐	☐	☐	Extensive (Medical Referral)
☐	☐	☐	Postpartum (Referral Linkage)
			Social/Psychological:
☐	☐	☐	Basic
☐	☐	☐	Subsequent
☐	☐	☐	Specialized (as needed)
☐	☐	☐	Extensive (Medical Referral)
☐	☐	☐	Postpartum (Referral/Linkage)
			Health Education:
☐	☐	☐	Instructions
☐	☐	☐	Services (Childbirth Class, Breastfeed, Parenting, etc.)
☐	☐	☐	Postpartum (Reinforcement, etc.)
☐	☐	☐	**Preventive Home Visit Assessment:** Prenatal and/or Postpartum
☐	☐	☐	**High Risk Home Visit Assessment:** Prenatal and/or Postpartum
☐	☐	☐	**Preventive Health Support Service:** Postpartum Contact (Refer/Link/Close) Before 6 Week Med. Visit
☐	☐	☐	Utilization of Existing Community Resources

Comments:

Name of DHSS Consultant	Signature	Date

Name of Agency Staff Person	Signature	Date

REIMBURSEMENT RATES* (AS OF 4/1/89) AND DESCRIPTION OF SERVICES (PACKAGE)
FOR
MATERNITY HEALTH SUPPORT SERVICES (PACKAGE)

DESCRIPTION	RATE	CODE
! Enrollment Process* - Assistance with presumptive eligibility determination for Maternity Care recipients, when and if applicable - Patient registration and scheduling of the initial appointments - Counseling and referral for WIC, food stamps and other community-based services - Assignment of HealthStart cases coordinator - Outreach and follow-up on missed appointments	$30.00	W9040 (Note - This code may be billed only once during pregnancy by the same provider.)
! Development of Maternity Plan of Care* - Case coordination services - Initial assessments 1. nutrition 2. health education 3. social/psychological - Case conference with Maternity Medical care provider - Initial plan of care developed by the HealthStart case coordinator - Basic guidance and health education services - Referral for other needed services including follow-up with County Welfare Agency "/Board of Social Services" - Outreach, referral and follow-up activities including phone calls and letters	$120.00	W9041 (Note - This code may be billed only once during pregnancy by the same provider.)
! Subsequent Maternity Health Support Services - Case coordination - Review and update of care plan - Coordination with maternity medical care provider - Health education instruction - Social/psychological guidance - Nutrition guidance - Home visit for high risk clients - Outreach, referral and follow-up activities including phone calls and letters	$50.00	W9042 May be billed once during 2nd and once during 3rd trimester and <u>not more</u> than twice per pregnancy

***** New Jersey Register Monday February 1, 1988.

****** These services must be provided prior to request for reimbursement and there must be adequate and sufficient documentation in the patient record to support this Division of Medical Assistance and Health Services Adopted New Rules: N.J.A.C. 10:49-3.1-3:20.

REIMBURSEMENT RATES* (AS OF 4/1/89) AND DESCRIPTION OF SERVICES (PACKAGE)
FOR
MATERNITY HEALTH SUPPORT SERVICES (PACKAGE)

DESCRIPTION	RATE	CODE
! Postpartum Maternity Health Support Services - Case coordination services - Review of the plan of care - Review of the summary of hospital stay records and current medical status - Nutrition assessment and counseling - Social/psychological assessment and counseling - Health education assessment and instruction - Home visit(s) as applicable - Referral, outreach and follow-up services including phone call "(.)" "and" letters - Referral for pediatric preventive care and follow-up - Transfer of pertinent information to pediatric, future family planning and medical care providers - Completion of the plan of care	$100.00	W9043

***** New Jersey Register Monday February 1, 1988.

****** These services must be provided prior to request for reimbursement and there must be adequate and sufficient documentation in the patient record to support this Division of Medical Assistance and Health Services Adopted New Rules: N.J.A.C. 10:49-3.1-3:20.

NEW JERSEY REGISTER, MONDAY, FEBRUARY 1, 1988 CITE 20 N.J.R. 285				
HCPCS	**MAXIMUM FEE ALLOWANCE**			**CODE**
	Spec.	**N Spec.**	**WM (CNM)**	
! **HealthStart*** - Initial antepartum maternity medical visit	$72.00	$69.00		W9025
! **HealthStart***			$67.00	W9025WM
- Initial antepartum maternity medical care visit by certified nurse midwife - History, including system review - Complete physical examination - Risk assessment - Initial care plan - Patient counseling and treatment - Routine and special laboratory tests on site, or by referral, as appropriate - Referral for other medical consultations, as appropriate (including dental) - *Coordination with the@ HealthStart AHealth* Support Services provider, as applicable - Case conference with HealthStart case coordinator				
! **HealthStart*** - Subsequent antepartum maternity medical care visit	$22.00	$21.00		W9026
! **HealthStart***			$19.00	W9026W
- Subsequent antepartum maternity medical care visit by certified nurse midwife - Interim history - Physical examination - Risk assessment - Review of plan of care - Patient counseling and treatment - Laboratory services on site or by referral, as appropriate - Referrals for other medical consultations, as appropriate - *Coordination with HealthStart case coordinator*				(Note - This code may be billed only for the 2nd through 15th antepartum visit.) (Note - If medical necessary dictates, corroborated by the record, additional visits above the initial and fourteen subsequent visits may be reimbursed under procedure code 90040, 90050, 90060, and* 90070. (90050 WM, *90060 WM, 90150 WM, 90160 WM, *routine or follow-up visit, midwife.)
! **HealthStart Regular Delivery**	$465.00	$418.00		*W9027

NEW JERSEY REGISTER, MONDAY, FEBRUARY 1, 1988 CITE 20 N.J.R. 285				
HCPCS	**MAXIMUM FEE ALLOWANCE**			**CODE**
	Spec.	**N Spec.**	**WM (CNM)**	
! HealthStart Regular Delivery by Certified Nurse Midwife - Admission History - Complete physical examination - Vaginal de-+livery with or without episiotomy - Inpatient postpartum care - Referral to postpartum follow-up care provider including: 1. Mother-s hospital discharge summary 2. Infant-s discharge summary, as appropriate			$317.00	W9027WM (Note: Obstetrical delivery applies to a vaginal delivery at full term or premature and includes care in the home, birthing center or in the hospital (inpatient setting).)
! HealthStart Postpartum Care Visit	$22.00	$21.00		*W9028
! HealthStart Postpartum Care Visit by Certified Nurse Midwife - Outpatient postpartum care by the 60th day after the vaginal or Cesarean section delivery - Review of prenatal, labor and delivery course - Interim history, including information on feeding and care of newborn - Physical examination - Referral for laboratory services as appropriate - Referral for ongoing medical care when appropriate - Patient counseling and treatment			$19.00	(Note - The postpartum visit shall be made by the 60th postpartum day.)
! HealthStart* Regular Delivery and Post-partum	$487.00	$439.00		W9029
! HealthStart* Regular Delivery and Post-partum by Certified Nurse Midwife - Admission History - Complete physical examination - *Vaginal delivery with or without episiotomy - Inpatient postpartum care - Referral to postpartum follow-up care provider including: 1. Mother-s hospital discharge summary 2. Infant-s discharge summary, as appropriate			$390.00	*W9029WM (Note - *This code* applies to a vaginal delivery at full term or premature and includes care in the home, birthing center or in the hospital (inpatient setting). This shall also include one post hospital discharge visit by the 60th postpartum day.

NEW JERSEY REGISTER, MONDAY, FEBRUARY 1, 1988 CITE 20 N.J.R. 285				
HCPCS	**MAXIMUM FEE ALLOWANCE**			**CODE**
	Spec.	**N Spec.**	**WM (CNM)**	
- Outpatient postpartum care by the 60th day after the delivery - Review of prenatal, labor and delivery course - Interim history, including information on feeding and care of the newborn - Physical examination - Referral of laboratory services as appropriate - Referral for ongoing medical care when appropriate - Patient counseling and treatment				
! HealthStart Total Obstetrical Care	$867.00			*W9030*
			$802.00	*[W9028WM]*
! HealthStart Total Obstetrical Care by Certified Nurse Midwife			$723.00	*W9030WM*
- Total obstetrical care consists of: 1. Initial antepartum visit and fourteen subsequent antepartum visits. 2. Obstetrical delivery per vagina with or without episiotomy including care when provided in the home, birthing center or in the hospital (inpatient setting). This applies to a vaginal delivery at full tem or premature. This shall also include one post hospital discharge visit by the 60th postpartum day.				(Note - Reimbursement will be decreased by the fee for the maternity medical care initial antepartum visit if the patient is not seen for this visit. The total fee will also be decreased by the reimbursement sum for each subsequent maternity medical care antepartum visit less then fourteen visits.)
! HealthStart Cesarean Section Delivery	$595.00	$531.00		*W9031
- Admission History - Complete physical examination - Cesarean section delivery - Inpatient postpartum care - Referral to postpartum follow-up care provider including: 1. Mother=s hospital discharge summary 2. Infant=s discharge summary, as appropriate				